HEALTH CARE RESPONSIBILITY ACT HANDBOOK

2016 Edition, Florida Agency for Health Care Administration

HCRA HANDBOOK

TABLE OF CONTENTS

The purpose of this handbook is to provide detailed uniform procedures and policies to hospitals, counties and the Agency in complying with the statutes and administrative rules governing the Health Care Responsibility ACT (HCRA).

Section	Section #
Chapter 1: Background and Overview	
How to Use the HCRA Handbook	1-1
How This Handbook is Divided	1-2
The Health Care Responsibility Act (HCRA)	1-3
1988 Legislation	1-4
HCRA Workgroup	1-5
1990 Legislation	1-6
1991 Legislation	1-7
1998 Legislation	1-8
2001 Legislation	1-9
2011 Legislation	1-10
2012 Legislation	1-11
Statutes and Rules Governing the HCRA	1-12
Administration of the HCRA Program	1-13
Overview of the Application, Eligibility and Claims Process	1-14
In-County Procedures	1-15
Program Descriptions	1-16
Chapter 2: County, Hospital and Agency Program Administration	
County Responsibilities	
Mandatory County Participation	2-1
Maximum County Financial Obligations	2-2
Which Agency Determines Eligibility	2-3
Spend-Down Provision Eligible Counties	2-4
Claims Payment	2-5
Expenditures	2-6
Monthly Caseload and Appeals Report	2-7
Quarterly Financial Report	2-8
Hospital Responsibilities	
Hospital Eligibility	2-9

Participating Hospitals 2-10
Two Percent Uncompensated Charity Care Obligation 2-11
2.5 Percent Uncompensated Out-of-County Charity Care Obligation 2-12
Incorrect Charity Care Data 2-13
Hospital Participation Start Date 2-14
Utilization Review 2-15
Utilization Review Plan 2-16
Patient Application Submission and Claim Submission Time Frames 2-17
Interim Medicaid Rate Changes 2-18

Agency for Health Care Administration Responsibilities

Eligibility Determination through the Agency 2-19
Florida Administrative Code Responsibilities 2-20
Development of Forms 2-21
Technical Assistance 2-22
Monitoring 2-23
Fiscal and Reporting Responsibilities 2-24

Agreements

County/Hospital Participation Agreements 2-25
Reimbursement Rate Agreements 2-26
County/Hospital Agreements Notification Requirements 2-27

Record Maintenance and Retention

County Records Requirements for Eligibility Determination 2-28
Hospital Responsibilities for Records Retention 2-29
Hospital Responsibilities for Claims Records 2-30
County Responsibilities for Claims Records 2-31

Chapter 3: Covered Services Emergency Care

Emergency Inpatient and Outpatient Services 3-1
Emergency Services and Ability to Pay 3-2
Emergency Hysterectomies 3-3
Abortions 3-4
Elective and Non-Emergency Services 3-5
Covered Oral Surgery 3-6
Sterilization 3-7
Organ Transplants 3-8
Hysterectomies 3-9

Inpatient Care

Definition of Inpatient 3-10
Inpatient Covered Services Included in the Inpatient Reimbursement Rate 3-11

Outpatient Care

Outpatient Services 3-12
Definition of Outpatient 3-13
Outpatients Subsequently Admitted as Inpatients 3-14

Limitations

Days of Care and Items Not Covered by HCRA 3-15
Reimbursement Limitations 3-16
Exceptions to the $1,500 Reimbursement Limit 3-17

Chapter 4: Application Process

Application Screening Requirements 4-1
The Application 4-2
Application Deadlines 4-3
Completing Part 1 of the Application – Household Information 4-4
Completing Part 2 of the Application – Financial Information 4-5
Completing Part 3 of the Application – Declaration 4-6
Completing Part 4 of the Application – Patient Information 4-7
Completing Part 5 of the Application – Referral Hospital 4-8
Providing Share of Cost Information to Counties for Spend-Down Provision Applicants 4-9
Reviewing the Completed Application 4-10
Applicant's Rights and Responsibilities 4-11

Chapter 5: Eligibility Determination Process

Eligibility Determination Deadlines 5-1
Certifying Agency's Receipt of Applications 5-2
County's Screening of the Applications 5-3
Required Interviews by the Certifying Agency 5-4
Determining if Applicant Resides in a Public Institution 5-5
Verification of Citizenship 5-6
Persons Categorically Eligible for a Government Program 5-7

Residency Determinations

Determining County of Residence 5-8
Acceptable Residency Documentation 5-9

Determining Household Size

Determining the Number of Persons in the Applicant's Family Unit 5-10

Determining Income Eligibility

Verification of the Family Unit's Income 5-11
Income to be Considered 5-12
Income Not Included 5-13
Determining if Income is within 100 Percent of the Poverty Guidelines 5-14

Determining Spend-Down Provision Eligibility

Verification of Income for Spend-Down Provision Applicants 5-15
Example of Meeting the Share of Cost 5-16
Hospital Expenses Counted toward Meeting the Applicant's Share of the Cost 5-17
Applicant's Medical Expenses Not Counted toward Meeting the Share of Cost 5-18
Final Determination of Applicant's Meeting the Share of Cost – UB-04 Claim Form 5-19

Determining Asset Eligibility

Evaluating the Applicant's Assets 5-20
Excluded Assets 5-21
Verification of Assets That Are Considered 5-22
Assets to Be Considered 5-23
Determining whether Assets Are within the Limits 5-24

Eligibility Notification

Completing the Notification of Eligibility 5-25
Examples of Completing the Notification of Eligibility for the Ineligible Applicant 5-26
Sending the Notification 5-27
Monthly Caseload and Appeals Report 5-28

Chapter 6: Claims Processing

Time Standards

Hospital Claims Processing Time Standards	6-1
Resubmitting a Denied Claim	6-2
County Claims Processing Time Standards	6-3
Hospital's Course of Action if Claims Processing Exceeds Time Standards	6-4

Hospital Responsibilities for Claims Submission and Processing

Basic Rules for Claim Preparation	6-5
Third Party Coverage	6-6
HCRA Payment as Payment in Full	6-7
Collecting the Applicant's Share of Cost	6-8
Refunding HCRA Payments to the County	6-9

County Responsibilities for Claims Processing

County's Review of Claim and Hospital Notification	6-10
In-Depth Review of UB-04 Claim Form	6-11
Review of Field of 19: Inpatient Care/Emergency Care	6-12
Adjudication of Claims by the County	6-13
Determining the Amount of Reimbursement for Inpatient Claims for Counties at Their 10 Mill Cap on Ad Valorem Taxes	6-14
Determining the Amount of Reimbursement for Inpatient Claims for Counties Not at Their 10 Mill Cap on Ad Valorem Taxes	6-15
Determining the Amount of Reimbursement for Inpatient Claims for Spend-Down Provision Applicants	6-16
Examples of Reimbursements to Hospitals for Spend-Down Provision Applicants	6-17
Determining the Amount of Reimbursement for Outpatient Claims for Non-Spend-Down Provision Applicants	6-18
Determining the Amount of Reimbursement for Outpatient Claims for Spend-Down Provision Applicants	6-19
Calculating Reimbursement with Third Party Insurance	6-20
No Retroactive Per Diem Rate Adjustments	6-21
Transmitting Reimbursement to the Hospital	6-22
Denied Claims	6-23
Failure to Provide Payment	6-24

State Comptroller Responsibilities

Hospital's Certification for Payment to the State Comptroller's Office	6-25

State Comptroller Responsibilities 6-26

Chapter 7: Appeal Process

Appeals 7-1
Time Standards 7-2
Ways that Appeals may be Conducted 7-3
Agency and DOAH Administrative Appeals 7-4
Request Format for an Informal Agency Hearing 7-5
Request Format for a Formal DOAH Hearing 7-6
Informal County-Level Appeals 7-7
QIO Appeals 7-8
Request Format for QIO Appeals 7-9
Appeal Reports 7-10

LIST OF APPENDICES

A. Definitions
B. Monthly Caseload and Appeals Report
C. Quarterly Financial Report
D. Out-of-County Charity Care Report
E. Sample Participation Agreement
F. Notification of Eligibility
G. Health Care Assistance Application
H. UB-04/CMS-1450 Claim Form and Completion Instructions
I. Sample Itemized Paid Claims – County Form Used to Provide Supporting Reimbursement Information to Hospitals
J. Current Fiscal Year HCRA Income Limits (100% poverty guidelines)
K. Current Fiscal Year HCRA Spend-Down Provision Income Limits

Chapter 1

Background and Overview

This handbook provides the basic information needed to effectively administer the Health Care Responsibility Act (HCRA). The appendices provide additional information necessary for hospital staff to process applications and bill for services rendered, and for county staff to determine eligibility and make payments to the hospitals.

All HCRA funds, whether in-county or out-of-county, are only to be used to reimburse hospitals for qualified indigent emergency or pre-approved non-emergency care. Please refer to Chapter 3, page 3-8 for services and care NOT covered by HCRA.

1-1 How to Use the HCRA Handbook: Each chapter covers a specific topic relative to the administration of the HCRA. Each chapter is divided into sections by topic. The topics appear in **bold** type at the beginning of each section.

1-2 How This Handbook Is Divided: This handbook is divided into the following chapters by topic:

Chapter 1 provides an **introduction** to the Health Care Responsibility Act (HCRA). It covers the background and history of the HCRA, and also provides a summary of the program's policies and procedures.

Chapter 2 specifies the **administrative responsibilities** of the counties, hospitals, and the Agency in regard to HCRA participation. It specifically covers the counties' mandatory participation in HCRA, hospital participation requirements, county reporting requirements, Agency requirements, and file maintenance and record retention requirements for both the counties and participating hospitals.

Chapter 3 provides information regarding the types of inpatient and outpatient **hospital services covered** through the HCRA. It also defines the days of care that are HCRA reimbursable and the maximum number of days which may be reimbursed.

Chapter 4 provides detailed information regarding the **application process**. Written particularly for the hospital, it explains how to complete the patient's application for HCRA, the time frames in which applications must be submitted to the county, the documents that the hospital will need to submit, and general applicant eligibility information.

Chapter 5 provides detailed information regarding the **eligibility determination process**. It is specifically written for the county; however, hospital staff will need to be familiar with it in order to do their part responsibly. This chapter covers the types of documentation required for residency determination, income determination, asset determination, and information regarding the spend-down provision. It also covers the time frames under which the county is required to determine eligibility.

Chapter 6 provides detailed information regarding the **claims process**. It specifically covers what the hospital must do to submit claims, what the county must do to process claims, the time frames for both, and the State Comptroller's responsibilities regarding claims processing. It also provides information regarding what the hospital may do if the county does not process a claim.

Chapter 7 provides information regarding the **appeals process**. It specifically covers the different types of appeals processes that are available for hospitals, counties and patients.

Definitions of HCRA terms used throughout this handbook are provided as Appendix A. You will need to understand these terms in order to thoroughly understand the HCRA.

Program Background Information

1-3 The Health Care Responsibility Act (HCRA): HCRA was first enacted in 1977. The original legislation placed ultimate financial obligation for an indigent patient's emergency care on the county in which the patient resides. However, the legislation did not require the following:

A. That each county set aside a specified amount of funds to provide for the care;

B. That uniform eligibility criteria be established for use in determining indigence; or

C. That hospitals other than the major regional referral hospitals be reimbursed by the county of residence.

As a result, when a hospital attempted to bill what it believed to be the county of residence, that county often times did not reimburse the hospital or disagreed with the hospital's claim that such person was indigent and/or a resident of the county billed.

1-4 1988 Legislation: The 1988 Legislature revised the act to address these issues and to prevent the burden of absorbing the cost of this uncompensated charity care from being borne by the hospital, the private pay patients, and, many times, by the taxpayers in the county where the hospital was subsidized by tax revenue. The Health Care Responsibility Act of 1988 required the following:

A. A maximum dollar amount of financial responsibility be set for each country;

B. Uniform eligibility criteria be used for all counties;

C. A standardized procedure be developed for determining the patient's county of residence; and

D. Administrative rules governing the Health Care Responsibility Act of 1988 be developed.

1-5 HCRA Workgroup: The 1988 Legislature further mandated that the health care community be involved in drafting the administrative rule. Therefore, the administrative rule was based on recommendations of a work group consisting of equal representation by the hospital industry, the counties and the Agency for Health Care Administration.

The HCRA work group first met in October 1988 to assure that problem areas were resolved and that the program achieved an optimal level of success. Although the work group is no longer active, seminars and other forums are held whenever changes occur or problem areas arise within the program.

1-6 1990 Legislation: The Governor and the 1990 Legislature made further program revisions. The out-of-county charity care obligation that hospitals had to meet to become eligible was reduced from 5 percent of charity care provided to 2.5 percent. The general charity care requirement of two percent did not change. These charity care requirements are further discussed in Sections 2-10., 2-11., and 2-12. In addition, program access was limited to U.S. citizens and legally admitted aliens. Residents at public institutions (such as prisons) were declared ineligible, and the 45 maximum days of coverage was revised to be determined on a county fiscal year basis (October 1 through September 30), rather than on a calendar year basis.

1-7 1991 Legislation: The Governor and the 1991 Legislature made revisions to increase, for certain counties, the number of persons eligible for the HCRA and to increase the rate at which those counties reimburse hospitals. Specifically, counties not at their 10-mill cap on ad valorem taxes by October 1, 1991, were required to do the following:

A. Reimburse hospitals at a payment rate equivalent to 100 percent of the hospitals' Medicaid per diem rates; and

B. Establish a spend-down program for persons who would otherwise qualify as eligible, but whose average family income, for 12 months preceding the determination, is between 100 percent and 150 percent of the poverty guidelines.

These changes did not apply to counties that were at the 10 mill cap on ad valorem taxes as of October 1, 1991. The counties at the 10 mill cap would continue to administer the HCRA program in the same way as they had previously done. Additionally, the legislation required that procedures in rule be adopted for the spend-down program in rule.

1-8 1998 Legislation: The 1998 Legislature revised the act to fulfill the important state interest of promoting the legislative intent of the Florida Health Care Responsibility Act. The following legislation was added to the act:

A. The maximum amount a county may be required to pay to out-of-county hospitals may be reduced by up to one half provided that the amount not paid has or is being

spent for in-county hospital care provided to qualified non-Medicaid indigent residents.

1-9 2001 Legislation: In 2001, the Legislature revised the Act to allow the Agency to reduce the maximum amount that a county having a population of 100,000 or less may be required to pay. The Agency must reduce the official state population estimates by the number of inmates and patients residing in the county in institutions operated by the Federal Government, the Department of Corrections, the Department of Health, or the Department of Children and Family Services, and by the number of active-duty military personnel residing in the county. A county is entitled to receive the benefit of this reduction only if the county accepts and does not require any re-verification of the documentation of financial eligibility and county residency provided to it by the participating hospital or statutory teaching hospital. The submitted documentation must be complete and in accordance with the requirements of Section 154.3105, Florida Statutes.

1-10 2011 Legislation: The 2011 Legislature mandated that, instead of semiannually, hospital rates are to be calculated annually effective July 1 of each year. In addition, the law enacted mandated that no adjustments be made to rates after October 31 of the state fiscal year in which the rate is effective. These rates may not be the final rates for certain hospitals and may change due to legislative authority allowing hospitals to buy back the Medicaid trend adjustment and other Medicaid limitations which apply to the individual hospital rate. As a result, hospital rates will be posted July 1 of each year.

1-11 2012 Legislation: To ensure all hospitals receive the same payment for rendering the same service, the 2012 Legislature directed the Agency to develop a plan to convert Medicaid inpatient hospital rates to a prospective payment system that categorizes each case into diagnosis-related groups (DRG). DRG transitions hospital inpatient reimbursement from a cost-based per diem to a per discharge, diagnosis-code payment. The only exception is for the State Mental Health Hospitals which will continue to be reimbursed per diem. It was estimated to be budget neutral at a statewide level, so some counties may pay more and others less. The DRG payment system was effective July 1, 2013.

1-12 Statutes and Rules Governing the HCRA: The Health Care Responsibility Act (HCRA) is governed by sections 154.301 through 154.331, Florida Statutes. The corresponding rules governing the HCRA are located in Chapter 59H-1, Florida Administrative Code.

This handbook is based on the requirements specified in these statutes and rules.

1-13 Administration of the HCRA Program: The Bureau of Central Services, Agency for Health Care Administration (also referred to as the Agency) is responsible for the day-to-day administration of the HCRA on a statewide level. The office was previously within the Florida Department of Health and Rehabilitative Services; however, the 1993 Legislature moved the Medicaid office to the Agency effective July 1, 1993. The mailing address and telephone number are as follows:

Agency for Health Care Administration
Bureau of Central Services
2727 Mahan Drive, Mail Stop Code 26
Tallahassee, Florida 32308

Telephone: (850)412-4333
Fax: (850)487-6240
Email: HCRA@ahca.myflorida.com

HEALTH CARE RESPONSIBILITY ACT (HCRA) OVERVIEW

1-14 Overview of the Application, Eligibility, and Claims Process: Through the HCRA, counties reimburse out-of-county hospitals for emergency care provided to the counties' indigent residents. Chapter 98-191, Laws of Florida, make it possible for counties to use up to one half of the county's HCRA funds to reimburse in-county hospitals for qualified non-Medicaid indigent patients. When an out-of-county, or in-county, hospital provides emergency care to a possibly indigent patient, the HCRA program is considered as a payment mechanism. As an aid in understanding how the HCRA program works, a brief description of the application process, eligibility determination review, and claims submission process is provided below.

Application Screening Process

A. First, the HCRA participating hospital screens the patient to determine if the patient is potentially eligible for the HCRA:

   1. Is the patient a resident of a Florida county?
   2. Is there inadequate third party payor coverage?
   3. Is the patient not eligible for other state programs?
   4. Is the patient not eligible for any federal program?
   5. Is the patient a U.S. citizen, or a legally admitted alien?
   6. Is the patient not residing in a public institution, such as a correctional facility?
   7. Are the patient's assets within the asset limits (as defined in Section 5 of this handbook)?

B. If the answers to the above questions are all "yes," the applicant is potentially eligible for the HCRA program. The hospital staff should then determine if the care provided to the patient is emergency care. If it is, the hospital should continue with the

application process. If the care provided was non-emergency care, the hospital must check to see if there is a written agreement or a pre- approval from the county of residence for the hospital to provide that patient's treatment, and that the treatment provided isnot available through county funding at a hospital located in the patient's county of residence.

1. For out-of-county: If the non-emergency services are available through county funding in the patient's county of residence, then the patient is not eligible for reimbursement through the HCRA.

2. For in-county: The HCRA would not apply to persons active with a county medical assistance plan if the treating hospital is a participating facility under the county's medical assistance plan.

3. For out-of-county: If the non-emergency services are not available in the patient's county of residence, and there is a written agreement between the county and the hospital for the hospital to provide those services, then those hospital services may be reimbursed by the county through the HCRA provided the patient is otherwise eligible.

4. For in-county: There must be a written agreement between the county and the hospital accepting the HCRA or other negotiated reimbursement standards provided the patient is otherwise eligible.

5. If the non-emergency services are not available in the county and there is no written agreement with the county, then such an agreement must be negotiated prior to services being provided in order for the patient to be eligible for HCRA hospital reimbursement.

6. For more information regarding the potential eligibility of patients requesting non-emergency services, see Elective and Non-Emergency Services, Section 3-5.

C. If the applicant has met the eligibility criteria described above, the applicant and the hospital complete the HCRA application. The hospital reviews the applicant's income. If it appears to be within the levels required for HCRA (100% of the poverty guidelines), the hospital should submit the application and any supporting income, asset and residency documentation to the county of residence.

Spend-Down Provision Eligibility

D. If the applicant's income appears to be between 101% and 150% of the poverty guidelines, the hospital checks to see if the applicant may be eligible for the HCRA through the spend- down provision:

1. Is the applicant a resident of a county that was not at its 10 mill cap on ad valorem taxes as of October 1, 1991?

2. If the answer to 1 is yes, the applicant is potentially eligible for the HCRA through the spend-down provision. The hospital should submit the application, an estimate of the hospital charges (which the county will need in order to determine potential eligibility for the spend- down provision), and any other supporting income, asset and residency documentation to the county of residence.

More information regarding the 10 mill cap and the spend-down provision may be found in Sections 2.4, 2.5, and Section 5.15 of this handbook.

Application Submission

E. The hospital must submit the HCRA application to the county of residence:

1. By certified mail; and

2. Within 30 calendar days from date of admission or receipt of emergency treatment. Failure to meet the time limit may cause the application to be denied by the certifying agency pursuant to Section 154.316(1), Florida Statutes. More information regarding the timeliness of applications may be found in Section 4-3., Application Deadlines, of this Handbook.

Eligibility Determination

F. The county determines eligibility upon receipt of the completed application:

1. By determining the timeliness of the application,

2. By determining residency,

3. By determining assets,

4. By determining citizenship,

5. By determining living address/shelter (public institution),

6. By determining income, and

7. If appropriate, by determining eligibility for HCRA through the spend-down provision, including determining the spend-down provision applicant's share of cost.

G. Based upon the information obtained through the determination process, the county must do the following:

1. Verify that the service provided was at a participating hospital;

2. Refer disputed residency cases to the Agency for resolution;

3. Determine eligibility, including eligibility for the spend-down provision, if appropriate, within 60 days. If the certifying agency cannot make an eligibility determination within the 60 days, a written explanation must be provided to the hospital; and

4. Complete and mail the Notification of Eligibility (NOE), to the applicant and hospital. The certifying agency may send the notification form via certified mail to insure delivery within the specified time frame.

Submitting the Claim Form

H. Upon receipt of the NOE for the eligible patient, the hospital completes the UB-04 claim form and submits it with a copy of the NOE to the county of residence. The hospital must submit these documents to the county within six months from the date the hospital received the NOE.

Reimbursing the Hospital

I. Upon receipt of the UB-04 claim form and copy of the NOE, the county proceeds by:

1. Verifying that the reimbursement is for covered services as outlined in Section 6-13 for inpatient and outpatient services,

2. Verifying that the reimbursement is within the inpatient or outpatient reimbursement limits, as appropriate (see Section 3-16., Reimbursement Limitations, and Section 3- 17., Exceptions to the $1,500 Reimbursement Limit, for more information regarding reimbursement limits),

3. Reimbursing the hospital for outpatient care provided at a rate equal to 100% of the Medicaid line item rates or other negotiated rate,

4. Reimbursing the hospital, if it is a county that was at its 10 mill cap on ad valorem taxes as of October 1, 1991, at a rate equal to 80% of Medicaid reimbursement rate for inpatient services or at another negotiated rate,

5. Reimbursing the hospital, if it is a county that was not at its 10 mill cap on ad valorem taxes as of October 1, 1991, at a rate equal to 100% of Medicaid reimbursement rate for inpatient services or at another negotiated rate,

6. Reimbursing the hospital, if for a spend-down provision eligible applicant, at the Medicaid rate or other negotiated rate, minus the applicant's share of cost,

7. Reimbursing the hospital within 90 days from the date the county received the UB-04.

State Comptroller Responsibilities

J. The hospital may submit the claim directly to the State Comptroller if the county does not reimburse the hospital within the required time frame. The State Comptroller will reimburse the hospital from any funds due the county.

1-15 In-County Procedures

All current policies and procedures governing out-of-county HCRA reimbursement will be utilized to govern in-county HCRA reimbursement. All participating hospitals must meet the 2% charity care obligation unless there is no other hospital(s) within the county to provide indigent care or if no other hospital(s) within the county meets the 2% charity care obligation. Under those circumstances, the county must provide the Agency with a written statement that no hospital within the county meets the 2% requirement.

In all cases, there must be a written agreement between the county and the in-county hospital accepting the HCRA or other negotiated reimbursement standards. A copy of the letter from the county to the hospital and a copy of the letter from the hospital to the county accepting the HCRA standards, or a copy of a signed contract, must be filed with the Agency. Upon receipt of the aforementioned letters or contract, the Agency will provide the in-county designated hospital(s) with the necessary forms and a copy of the HCRA Handbook. There is no limit to the number of HCRA qualified in-county hospitals that a county may elect to contract with.

The county is then responsible for completing the In-County information on the Monthly Caseload and Appeals Reports and the Quarterly Financial Reports.

The applicant must be a resident of the county where the hospital is located and services were provided and the county must have elected to reimburse its in-county hospitals. All in-county HCRA applicants must meet the same HCRA eligibility requirements used for out-of-county

eligibility determination. If the county has established less restrictive requirements, the applicant would be required to meet the county's requirements on file with the Agency. The HCRA would not apply to persons active with a county medical assistance plan if the treating hospital is a participating facility under the county's medical assistance plan.
The HCRA is the payor of last resort.

The maximum amount of HCRA funds that a county can allocate for in-county reimbursement is up to ½ of its total HCRA funds, i.e., if a county must designate $500,000 for the fiscal year, it can only use a maximum of $250,000 for in-county hospital reimbursements. No county has the statutory authority to use out- of-county designated funds to supplement its in-county reimbursement amount above the aforementioned one half. Should a county exceed its designated in-county reimbursement limit, the additional funds must be provided through other funding sources from the county's budget and the amount exceeded shall not reduce the out-of-county obligation.

All counties must notify the Agency of its decision to provide in- county reimbursement starting with the county fiscal year 1999- 2000. Any changes to its decision must be filed with the Agency along with copies of notifications to the affected in-county hospitals no later than 45 days following the start of the new
county fiscal year in which the change takes effect (on or around November 14).

All HCRA funds, whether in-county or out-of-county, are only to be used to reimburse hospitals for qualified indigent emergency or pre-approved non-emergency care. Please refer to the current HCRA Handbook, page 3-8 for services and care NOT covered by HCRA.

1-16 Program Descriptions: The program descriptions on the following pages describe in short detail the policies and requirements of this program and may be photocopied as a quick reference guide.

Health Care Responsibility Act (HCRA) Fact Sheet	
Effective Date	1977 – Mandatory for All Counties
Basic Purpose	Reimburse out-of-county hospitals for emergency services (in-patient and outpatient) provided to county indigents. 1998 - Counties can now reimburse in-county participating hospitals for emergency services (in-patient and outpatient) provided to county indigents
Funding	100 percent county – maximum county fiscal year liability is $4 per capita (county population). Counties with a population of 100,000 or less can reduce the funding based on number of persons living in institutions operated by the Federal Government, the Department of Corrections, the Department of Health or the Department of Children and Family Services, and by the number of active-duty military personnel residing in the county. In order to make this reduction, the county must accept without re- verification documentation provided by the filing hospital regarding financial eligibility and county residency as long as the documentation complies with section 154.3105, F.S.
Eligible Persons	• Out-of-county resident • Not eligible for Medicaid or other state or federal health care programs • No or inadequate insurance • Income of up to 150% of poverty, if a resident of a county which was NOT at its 10 mill cap on ad valorem taxes as of October 1, 1991 (such persons must spend down to 100% of the poverty guidelines) • Assets up to the medically needy limit • Not a resident of a public institution • Is a U.S. citizen or lawfully admitted alien
Who Determines Eligibility	County performs function itself. If unable, the Agency may perform function.
Participating Health Criteria	Must meet two percent over-charity care obligation and have either: • An agreement with resident county to treat its indigent poor; or • Have 2.5% of its uncompensated charity care generated by out-of-county residents
Covered Services	• Emergency out-patient up to $1,500 per year • Emergency in-patient up to 45 days per county fiscal year • Elective and non-emergency, only if prior approved by county of residence and service not available in county of residence
Reimbursement Rates	• Emergency outpatient – 100% Medicaid line item reimbursement rate, unless another reimbursement rate is negotiated • Emergency in-patient – 80% of hospital's Medicaid rate if county was at its 10 mill cap as of October 1, 1991; otherwise, reimbursement is set at 100% of the Medicaid rate, unless another rate is negotiated • Elective or non-emergency – Same reimbursement rates as for emergency services • Reimbursement for covered services is considered payment in full. Recipients cannot be billed for remaining balances for services reimbursed through HCRA.

Health Care Responsibility Act

HISTORY: The Health Care Responsibility Act (HCRA) was first enacted in 1977 and revised by the 1988 Legislature to place the financial obligation for reimbursing hospitals for emergency in-patient and out-patient services provided to out-of- county indigent patients on the counties in which the patients reside.

The 1991 Legislature amended the Act to increase the number of eligible applicants through the creation of a spend-down program and to increase hospital reimbursement rates. Both of these measures pertained ONLY to counties that were not at their 10 mill cap on ad valorem taxes as of October 1, 1991. Such counties are referred to as spend-down provision eligible counties.

The 1998 Legislature further amended the Act to allow counties to reimburse in- county eligible hospitals up to one-half of the total HCRA funds for non-Medicaid indigent residents.

In 2001, the Legislature revised the Act to allow Agency to reduce the maximum amount that a county having a population of 100,000 or less may be required to pay. The Agency must reduce the official state population estimates by the number of inmates and patients residing in the county in institutions operated by the Federal Government, the Department of Corrections, the Department of Health, or the Department of Children and Family Services, and by the number of active-duty military personnel residing in the county. A county is entitled to receive the benefit of this reduction only if the county accepts and does not require any re- verification of the documentation of financial eligibility and county residency provided to it by the participating hospital or statutory teaching hospital. The submitted documentation must be complete and in accordance with the requirements of Section 154.3105, Florida Statutes.

Covered Services: The Act covers emergency services provided on either an inpatient or outpatient basis. The county may choose to cover elective and non- emergency services if such services are not available at a county funded hospital within the patient's county. The county may choose to cover services for in-county indigent care beginning July 1, 1998 for services at participating hospitals within the patient's county.

Hospital Eligibility Criteria: To receive reimbursement, a hospital must meet minimum standards. Teaching hospitals that meet the two-percent overall charity care obligation also are eligible for HCRA. Non-teaching hospitals must first be certified by the Agency for Health Care Administration, Bureau of Central Services, Financial Analysis Unit as having met a two-percent charity care obligation and then have either:

- Demonstrated to the Financial Analysis Un it that at least 2.5% of its overall charity care was provided to out-of-county residents; or

- Have an agreement with the patient's county of residence to provide emergency care to that county's indigent population.

Applicant Eligibility Criteria: To be eligible, an applicant must:

- Have received services covered by HCRA at a HCRA eligible out-of-county hospital;
- Have received services covered by HCRA at a HCRA eligible in-county hospital if the county uses up to one-half of its HCRA funds for in-county indigent care;
- Be certified by the county or the Agency as being a county resident;
- Have at a maximum, if a resident of a county, which was at its 10 mill cap on ad valorem taxes, a gross income of 100% of the poverty guidelines;
- Have at a maximum, if a resident of a spend-down provision eligible county, a gross income of 150% of the poverty guidelines, provided the applicant "spends down" to 100% of the poverty guidelines;
- Not be eligible for any other federally or state funded hospital reimbursement program (such as Medicaid or Medicare);
- Not live in a public institution;
- Have assets less than the Medicaid medically needy levels;
- Have no or inadequate private insurance; and
- Be a U.S. citizen or lawfully admitted alien.

Application Processing Responsibilities for the Hospital: The hospital providing emergency services to the indigent is responsible for submitting an application (AHCA Form 5220-0001) by certified mail to the indigent applicant's county of residence within 30 days of the date that the emergency inpatient or outpatient services were provided.

Applications Processing Responsibilities for the County: The county of residence is responsible for determining residency and eligibility. If the county is unable to determine residency, the Agency will determine residency for the county. The county has the right of refusal in determining HCRA eligibility. If the county so chooses, the eligibility function will be performed by the Agency for Health Care Administration office in Tallahassee.

The county must notify the hospital and the patient regarding eligibility within 60 days of receipt of the completed application by using the Notification of Eligibility. If the certifying agency cannot determine eligibility within the 60 days, a written explanation must be provided to the hospital.

Hospital/County Reimbursement Procedures: Upon receipt of the notice that the patient is eligible, the hospital has six (6) months to submit its claim to the county of residence. The county has 90 days to reimburse the hospital. If payment is not received, the hospital may certify to the State Comptroller the amount owed by the county. The Comptroller will then pay the hospital (within 45 days of receipt of the claim) from any revenue sharing or tax-sharing funds due the county, except as otherwise provided by the state constitution.

The hospital must refund the county or the State Comptroller for any payments received from third party payers or from any federal or state programs.

Hospital Reimbursement: Counties are obligated to pay up to 45 days of out-of- county hospital services per eligible HCRA applicant per county fiscal year. The maximum amount that a county is obligated to spend through HCRA for any county fiscal year is $4 per capita. The out-of-county amount may be lessened to one-half if the funds are used to pay for in-county hospital services for qualified non- Medicaid indigent residents.

For patients who are residents of counties, which were at their 10 mill cap on ad valorem taxes at October 1, 1991, counties must reimburse hospitals at 80% of their Medicaid per diem rates, unless another reimbursement rate is negotiated. For patients who are residents of spend-down provision eligible counties, counties must reimburse hospitals at 100% of their Medicaid rates, unless another reimbursement rate has been negotiated. **HCRA reimbursement for covered services is considered payment in full and the hospital cannot charge the recipient for any remaining balance.**

Agency Responsibilities: The Agency provides technical assistance to counties and participating hospitals, which include providing the following information: each county's maximum fiscal obligation, a HCRA handbook, and lists of all eligible hospitals, spend-down provision eligible counties, Medicaid reimbursement rates (sent each July), and county and hospital contacts.

Health Care Responsibility Act Spend-Down Provision Information

The spend-down provision is a way in which county residents who do not meet the HCRA income criterion may become eligible for HCRA by meeting a share of cost requirement. To be eligible for the HCRA spend-down provision, an applicant must be a resident of a Florida county which was NOT at its 10 mill cap on ad valorem taxes as of October 1, 1991, and meet all HCRA eligibility criteria, except income.

The spend-down provision is unnecessary for applicants whose family income is less than or equal to 100% of the poverty guidelines. Such applicants meet the HCRA income requirements.

If an applicant's income is between 100% and 150% of the poverty guidelines, then he/she may qualify for HCRA by using the spend-down provision.

Spend-Down Provision Applicant Requirements

To be eligible, an applicant must meet all of the following:

A. Be a resident of a county which was not at its 10 mill cap on ad valorem taxes as of October 1, 1991;

B. Meet the definition of a qualified non-Medicaid indigent patient as defined in Section 59H-1.0035(32), Florida Administrative Rule, excluding the income requirement;

C. Have a gross family unit income, for the 12 months preceding the determination, between 100% and 150% of the poverty guidelines; and

D. Have incurred out-of-county hospital expenses of an amount which exceeds the applicant's share of cost.

Share of Cost Definition

The share of cost is the difference between the spend-down provision applicant's monthly gross family income and the amount of income equal to 100% of the poverty guidelines specified for the applicant's family unit size.

Recap of Policy and Procedure for In-County Hospital Reimbursements

All current policies and procedures governing out-of-county HCRA reimbursement will be utilized to govern in-county HCRA reimbursement. All participating hospitals must meet the 2% charity care obligation unless there is no other hospital(s) within the county to provide indigent care or if no other hospital(s) within the county meets the 2% charity care obligation. Under those circumstances, the county must provide the Agency with a written statement that no hospital within the county meets the 2% requirement.

In all cases, there must be a written agreement between the county and the in-county hospital accepting the HCRA or other negotiated reimbursement standards. A copy of the letter from the county to the hospital and a copy of the letter from the hospital to the county accepting the HCRA standards, or a copy of a signed contract, must be filed with the Agency. Upon receipt of the aforementioned letters or contract, the Agency will provide the in-county designated hospital(s) with the necessary forms and a copy of the HCRA Handbook. There is no limit to the number of HCRA qualified in-county hospitals that a county may elect to contract with.

The county is then responsible for completing the In-County information on the Monthly Caseload and Appeals Reports and the Quarterly Financial Reports.

The applicant must be a resident of the county where the hospital is located and services were provided and the county must have elected to reimburse its in-county hospitals. All in-county HCRA applicants must meet the same HCRA eligibility requirements used for out-of-county eligibility determination. If the county has established less restrictive requirements, the applicant would be required to meet the county's requirements on file with the Agency. The HCRA would not apply to persons active with a county medical assistance plan if the treating hospital is a participating facility under the county's medical assistance plan. The HCRA is the payor of last resort.

The maximum amount of HCRA funds that a county can allocate for in-county reimbursement is up to ½ of its total HCRA funds, i.e., if a county must designate $500,000 for the fiscal year, it can only use a maximum of $250,000 for in-county hospital reimbursements. No county has the statutory authority to use out-of-county designated funds to supplement its in-county reimbursement amount above the aforementioned one half. Should a county exceed its designated in-county reimbursement limit, the additional funds must be provided through other funding sources from the county's budget and the amount exceeded shall not reduce the out-of-county obligation.

All counties must notify the Agency of its decision to provide in-county reimbursement starting with the county fiscal year 1999-2000. Any changes to its decision must be filed with the

Agency along with copies of notifications to the affected in-county hospitals no later than 45 days following the start of the new county fiscal year in which the change takes effect (on or around November 14).

All HCRA funds, whether in-county or out-of-county, are only to be used to reimburse hospitals for qualified indigent emergency or pre-approved non-emergency care. Please refer to the current HCRA Handbook, page 3-8 for services and care NOT covered by HCRA.

Chapter 2

County, Hospital, and Agency Program Administration

This chapter covers the administrative responsibilities of the county, the hospital, and the Agency as pertaining to the Health Care Responsibility Act (HCRA). All Florida counties are required to participate in the HCRA. Counties are required to pay only for emergency hospital care provided by out-of-county HCRA participating hospitals.

County administration of the HCRA is discussed under the **County Responsibilities** heading. Statewide Agency responsibilities are described in the **Agency for Health Care Administration** heading. The criteria for becoming a statewide participating hospital are discussed under the **Hospital Responsibilities** heading. Hospital and county participation agreements are discussed under the **Agreements** heading. Record retention requirements for both hospitals and counties are discussed under the **Record Maintenance and Retention** heading.

County Responsibilities

2-1 Mandatory County Participation: All counties are required to participate in HCRA effective January 1, 1989, up to their maximum financial obligation and to provide adequate staffing to timely process claims within the 60 day statutory time frame.

2-2 Maximum County Financial Obligation: A county is obligated to provide reimbursement for out-of-county hospital care for no more than a maximum financial obligation of $4 per capita per county fiscal year. However, in 1998, the Legislature revised the act to give counties the option of using up to one half of the HCRA funds to reimburse in-county hospitals for qualified non-Medicaid indigent patients.

The maximum amount of HCRA funds that a county can allocate for in-county reimbursement is up to ½ of its total HCRA funds, i.e., if a county must designate $500,000 for the fiscal year, it can only use a maximum of $250,000 for in-county hospital reimbursements. No county has the statutory authority to use out-of-county designated funds to supplement its in-county reimbursement amount above the aforementioned one half. Should a county exceed its designated in-county reimbursement limit, the additional funds must be provided through other funding sources from the county's budget and the amount exceeded shall not reduce the out-of-county obligation.

In 2001, the Legislature revised the Act to allow Agency to reduce the maximum amount that a county having a population of 100,000 or less may be required to pay. The Agency must reduce the official state population estimates by the number of inmates and patients residing in the county in institutions operated by the Federal Government, the Department of Corrections, the Department of Health, or the Department of Children and Family Services, and by the number of active-duty military personnel residing in the county. A county is entitled to receive the benefit

of this reduction only if the county accepts and does not require any re-verification of the documentation of financial eligibility and county residency provided to it by the participating hospital or statutory teaching hospital. The submitted documentation must be complete and in accordance with the requirements of Section 154.3105, Florida Statutes.

A. The Agency determines the maximum amount of the county's financial obligation under the HCRA and notifies each county of such by March of each year. The Agency determines the county's financial obligation by using the most recent official state population estimate for the total county population, which is published by the Florida Legislature's Office of Economic and Demographic Research for the coming fiscal year.

B. A county that reaches its out-of-county or in-county maximum financial obligation before the end of the county's fiscal year is responsible for the following:

   1. Notifying those participating hospitals with which they have agreements and those out-of-county state-wide participating hospitals which serve county residents that it will make no further payments under this program for the remainder of the county's fiscal year;

   2. Not making current year payments from funds allocated to this program for the previous or following county fiscal year; and

   3. Certifying such to the Agency within 60 days of the date the maximum is reached. The county must send the certification on county letterhead to the address specified in the Chapter 1, Section 1-10.

   4. All counties must notify the Agency of its decision to provide in-county reimbursement starting with the county fiscal year 1999-2000. Any changes to its decision must be filed with the Agency along with copies of notifications to the affected in-county hospitals no later than 45 days following the start of the new county fiscal year in which the change takes effect (on or around November 14).

   5. All counties with a population of 100,000 or less, must notify the Agency of its decision to participate in the reduction of its population starting with the county fiscal year 2001-2002. For those counties wishing to participate, the Agency will reduce the official state population estimates by the number of inmates and patients residing in the county in institutions operated by the Federal Government, the Department of Corrections, the Department of Health, or the Department of Children and Family Services, and by the number of active-duty military personnel residing in the county. The county must accept documentation on financial eligibility and county residency, must not require any re-verification of the documentation provided by the filing hospital. The documentation must comply with Section 154.3105, Florida Statutes. Any changes to the county's decision to participate must be filed with the Agency no

later than 45 days following the start of the new county fiscal year in which the change takes effect (on or around November 14).

2-3 Which Agency Determines Eligibility: Eligibility determination is made by the appropriate county or by the Agency as follows:

A. If the county cannot establish eligibility within 60 days after receiving an application via certified mail from the treating hospital or if the treating hospital appeals the decision of the county, then the Agency must perform this task.

B. The county must use the eligibility criteria prescribed by rule when determining eligibility. However, the county may choose less restrictive income and/or asset standards. If the county does, it must notify the Agency in writing of those standards used, within thirty days of making such decision.

C. The county must also provide the Agency with the names, titles, telephone numbers, and addresses of the individuals who are responsible for eligibility determination and claims processing. The county is responsible for informing the Agency of any changes in this information by writing to the address specified in Chapter 1, Section 1-10, within thirty days of making such changes.

D. Counties must determine applicant eligibility within 60 days of application receipt, except under the circumstances provided for in rule and specified in Chapter 5. Failure to do so will allow the hospital to submit the application to the Agency for eligibility determination. The Agency's determination is binding upon the county. See Florida Statute 154.309(2).

2-4 Spend-Down Provision Eligible Counties: Counties that were not at their 10 mill cap on ad valorem taxes as of October 1, 1991, are considered spend-down provision eligible counties. Such counties will reimburse hospitals at 100 percent of the Medicaid rates for inpatient and outpatient care, unless another reimbursement rate has been negotiated. Applicants of such counties whose incomes are between 101 and 150 percent of the poverty guidelines, and who are otherwise eligible, are eligible for HCRA reimbursement provided their hospital expenses exceed their share of cost. Further information regarding the spend-down provision is located in Chapters 5 and 6 of this handbook.

A. The Florida Department of Revenue determined which counties were at their 10 mill cap as of October 1, 1991.

B. The Agency is responsible for notifying each county of its status as a spend-down provision eligible county. The counties not at their 10 mill cap and eligible for the spend-down provision are: Alachua, Baker, Bay, Bradford, Brevard, Broward, charlotte, Citrus, Clay, Collier, Columbia, DeSoto, Duval, Escambia, Flagler, Franklin, Glades, Gulf,

Hamilton, Hendry, Hernando, Highlands, Hillsborough, Indian River, Lake, Lee, Leon, Levy, Madison, Manatee, Marion, Martin, Monroe, Nassau, Okaloosa, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Putnam, St. Johns, St. Lucie, Santa Rosa, Sarasota, Seminole, Suwanee, Taylor, Volusia and Walton.

2-5 Claims Payment: The county is responsible for paying claims to the hospital in accordance with the procedures indicated in rule and in Chapter 6 of this handbook.

A. Counties **not** at their 10 mill cap on ad valorem taxes reimburse hospitals at 100 percent of the Medicaid rates for inpatient and outpatient care. For spend-down provision applicants, such counties must subtract the applicant's share of cost from the amount of reimbursement the hospital would normally receive. The applicant is responsible for paying the share of cost amount to the hospital.

B. Counties at their 10 mill cap on ad valorem taxes must reimburse hospitals at 80 percent of the Medicaid rates for inpatient care and at 100 percent of the Medicaid line item rates for outpatient care, unless another reimbursement rate has been negotiated. The counties at their 10 mill cap and not eligible for the spend-down provision are: Calhoun, Dade, Dixie, Gadsden, Gilchrist, Hardee, Holmes, Jackson, Jefferson, Lafayette, Liberty, Okeechobee, Sumter, Union, Wakulla and Washington.

C. Counties must reimburse hospitals within 90 days of receiving the applicant's UB-04 claim form.

D. If a county does not reimburse a hospital within 90 days of receiving the claim, the hospital may seek reimbursement from county funds through the State Comptroller's Office.

2-6 Expenditures: If an indigent county resident cannot receive needed services within his county of residence because there is no hospital or because the hospitals within the county do not provide the type of service the indigent resident needs (therefore necessitating services be received from an out-of- county hospital), the county may choose to pay for such services from HCRA.

2-7 Monthly Caseload and Appeals Report: Each month, the county must complete a Monthly Caseload and Appeals Report, documenting caseload activity for the previous month. The county must submit this report to the Agency by the 15th of each month. The Agency's address is specified in Chapter 1, Section 1-10. A copy of this report is provided as Appendix B. The report is completed as follows:

A. Enter the county's name and the month for which the report is being submitted.
B. Enter in Part I the number of caseload dispositions (approvals/denials), reasons for denials, and number of applications still pending at the end of the report month.

C. Enter in Part II the number of appeals approved, denied and pending for the month.

D. Part III, enter the name, title, address and phone number of the person responsible for completing the report. This individual must then sign and date the report.

2-8 Quarterly Financial Report: The county must submit quarterly financial reports on expenditures and claim activity to the Agency at the address specified in Chapter 1, Section 1-10. The county must submit this report within 30 days from the end of each county fiscal year quarter. See Appendix C for a copy of the Quarterly Financial Report.

A. This report must include:

1. Total expenditures for the quarter;

2. For spend-down provision eligible counties, a breakdown of spend-down provision claim expenditures and regular HCRA expenditures;

3. Total expenditures for the fiscal year to date;

4. Number of claims reimbursed for the quarter;

5. For spend-down provision eligible counties, a breakdown of the number of spend-down provision claims and regular HCRA claims;

6. Total number of claims for the fiscal year to date; and

7. Number of claims denied for the quarter, broken down for spend-down provision eligible counties into the number of spend-down provision claims denied and regular HCRA claims denied.

B. The county must track expenditures as those occur during the course of each fiscal year.

C. The county must keep supporting claim documentation attached to these quarterly reports.

1. This supporting documentation must include a legible copy of the UB-04 claim form for each claim paid during the period reported.

2. This supporting documentation may include copies of the attachment(s) that accompanied the reimbursement check(s) to the hospital.

Hospital Responsibilities

2-9 Hospital Eligibility: Hospital eligibility is determined annually by the Agency's Financial Analysis Unit and is based on the hospital's previous fiscal year-end information. For example, a hospital's eligibility for the 1994-95 county fiscal year (October 1 through September 30) is based on the hospital's 1993 fiscal year-end data.

2-10 Participating Hospitals: The following types of hospitals may elect to become participating HCRA providers:

A. The statutory teaching hospital which has met its two percent charity care obligation.

B. The hospital that has met its two percent charity care obligation and has a current, formal signed agreement with a county or counties to treat such county's indigent patients. (A copy of that agreement shall be sent to the following address within thirty calendar days of its being signed: Agency for Health Care Administration, Bureau of Central Services, Attn: HCRA Program, 2727 Mahan Drive, Mail Stop Code 26, Tallahassee, FL 32308)

C. The hospital that has met its two percent charity care obligation and has demonstrated to the Agency for Health Care Administration, Bureau of Central Services, Financial Analysis Unit (Financial Analysis Unit) that at least 2.5 percent of its uncompensated charity care was generated by out-of-county indigent residents.

Hospitals with questions regarding participation in the HCRA Program should contact the Agency's HCRA liaison via email at HCRA@ahca.myflorida.com.

2-11 Two Percent Uncompensated Charity Care Obligation: To be potentially eligible, all hospitals must meet a two percent charity care obligation. This obligation is the ratio of uncompensated charity care days compared to the total acute care inpatient days based on the hospital's most recent audited actual experience. The hospital reports this information annually to the Financial Analysis Unit on the hospital's fiscal year-end report. The Financial Analysis Unit will notify hospitals if they meet the two percent overall charity care obligation.

2-12 2.5% Uncompensated Out-of-County Charity Care Obligation: To participate in the HCRA on a statewide basis, a non-teaching hospital must generate at least 2.5 percent of its uncompensated charity care from out-of-county patients. If a hospital has met the two percent overall charity care obligation, the Financial Analysis Unit will provide it with an Out-of-County Charity Care Report to be completed and submitted to the Financial Analysis Unit by May 1 of each year.

The Out-of-County Charity Care Report will provide the Financial Analysis Unit with hospital fiscal year-end information needed for the Financial Analysis Unit to determine if the hospital has met the 2.5 percent out-of-county charity care obligation. A copy of this report, in the format prescribed by the Financial Analysis Unit, is provided as Appendix D. The hospital must include the following information on the report:

A. The patient identification number, city and county of residence for each out-of-county indigent patient. The hospital may also include out-of-state patients; for such patients, the hospital must report the state of residence in place of the county of residence.

B. The amount of the bill for each such patient, the amount written off as charity care, and the date during the hospital's fiscal year that the account was written off as charity care.

C. A description of the supporting documentation used by the hospital for verification of residency.

   1. For HCRA, the Financial Analysis Unit accepts as documentation any of the documents used for the purpose of residency determination (see Chapter 5, Section 5-8).

   2. In lieu of the above, the Financial Analysis Unit will accept a statement signed by the patient or his legal guardian or designated representative attesting to the patient's county of residence.

Based on this information, the Financial Analysis Unit will notify the Bureau of Central Services by August 31 if this requirement has been met.

Hospitals with questions regarding the fiscal year charity care information and completing the Out-of-County Charity Care Report should contact:

Agency for Health Care Administration
Bureau of Central Services, Financial Analysis Unit
2727 Mahan Drive, Mail Stop Code 28
Tallahassee, Florida 32308
Phone: (850) 412-3951

2-13 Incorrect Charity Care Data: If, after a hospital has been determined eligible, the Financial Analysis Unit finds that the hospital incorrectly reported charity care information and that, based upon corrected data, the hospital was not eligible to participate, the hospital's eligibility will be rescinded. The hospital will also be required to repay to the county any amounts the hospital received for patients treated during the period for which its eligibility was rescinded.

2-14 Hospital Participation Start Date: The Agency will provide a list of eligible hospitals and their dates of eligibility to those hospitals and to all Florida counties by September 15 of each year.

2-15 Utilization Review: Each participating hospital which provides inpatient services must have a utilization review committee. The hospital will utilize the review committee established

for Medicaid. For utilization review policy refer to the HRSM 230-30 manual. The review committee must act as follows:

A. Have a utilization review plan which provides for the review of each patient's need for hospital services;

B. Be composed of two or more physicians and assisted by other professional personnel;

C. Constitute a committee of the hospital; and

D. Not include any individual with a financial interest in the hospital.

2-16 Utilization Review Plan: The utilization review plan must provide that each patient's record include information that is required by the utilization review committee to conduct the following reviews:

A. Admissions reviews.

B. Initial continued stay reviews.

C. Continued stay reviews.

2-17 Patient Application Submission and Claim Submission Time Frames: The hospital must submit the patient's application and any supporting documentation within 30 days of the date of admission or receipt of treatment, except as indicated in Chapter 4. The hospital must submit claims for patients determined eligible by the county certifying agency within six months of the date it received notification from the county that the patient was determined eligible. Additional information regarding claims processing is located in Chapter 6.

2-18 Interim Medicaid Rate Changes: The Agency notifies hospitals and counties of Medicaid inpatient and outpatient rates each July. However, the hospital is responsible for notifying the county of **any interim adjustments** to its outpatient per diem rates. The outpatient per diem rate utilized at the time of claim adjudication is considered the final rate for that claim. No retroactive per diem rate adjustment is allowed.

Agency for Health Care Administration Responsibilities

2-19 Eligibility Determination through the Agency: The Agency can determine eligibility when the county does not perform this function within 60 days of receiving the notification from the treating hospital or if the county chooses not to perform this function as discussed in Chapter 5.

2-20 Florida Administrative Code Responsibilities: The Agency is responsible for the administrative rules that governs this program. The Agency is also responsible for updating and amending the rules as necessary.

2-21 Development of Forms: The Agency is responsible for developing, printing, and distributing forms and applications as needed. The Agency is also responsible for providing instructions for the completion of such forms.

2-22 Technical Assistance: The Agency provides the following technical assistance to counties, hospitals, other agencies, and the general public:

A. Maintenance and distribution of the HCRA Handbook.

B. Training or technical assistance to counties and hospitals as needed.

C. Policy interpretations and general program information through telephone conversation and written correspondence.

2-23 Monitoring: The Agency conducts on-site program and fiscal monitoring at hospitals, certifying agencies, and claims payment agencies. Monitoring will be by exception and based on complaints received, review of caseload reports, or requests for technical support.

2-24 Fiscal and Reporting Responsibilities: The Agency provides the following data to participating counties and hospitals and also provides updates on an as needed basis:

A. A list of the Medicaid rates for hospitals as of July 1.

   NOTE: The hospital is responsible for notifying the county of any interim adjustments to its outpatient per diem rate. The outpatient per diem rate utilized at the time of claim adjudication is considered the final rate for that claim. No retroactive per diem rate adjustment is allowed.

B. A list of each county's maximum fiscal year financial responsibility toward the HCRA. This data is sent to counties by March 1 of each year.

C. A list of participating hospitals by September 15 of each year.

D. A list of contact persons at each county, updated each September.

E. A list of contact persons at participating hospitals, updated each September.

Agreements

2-25 County/Hospital Participation Agreements: All participating hospitals must meet the 2% charity care obligation unless there is no other hospital(s) within the county of residence to provide indigent care or if no other hospital(s) within the county of residence meets the 2% charity care obligation. Under those circumstances, the county must provide the Agency with a written statement that no hospital within the county meets the 2% requirement.

In all cases, there must be a written agreement between the county and the in-county hospital accepting the HCRA or other negotiated reimbursement standards. A copy of the letter from the county to the hospital and a copy of the letter from the hospital to the county accepting the HCRA standards, or a copy of a signed contract, must be filed with the Agency. There is no limit to the number of HCRA qualified in-county hospitals that a county may elect to contract with.

For a county to participate with a hospital that is neither a teaching hospital nor has met its 2.5 percent out-of-county charity care obligation, it must have a formal, signed agreement with the hospital to treat the county's indigent patients. However, all such hospitals must have met the 2.0 percent general charity care requirement in order to enter into an agreement with a county. There is no limit to the number of out-of-county hospitals with which counties may have agreements or vice versa.

2-26 Reimbursement Rate Agreements: The hospital must negotiate a reimbursement rate agreement with the county if it does not agree to the standard reimbursement rates. Standard reimbursement rates are as follows:

A. 80 percent of the Medicaid rate for inpatient hospital services and 100 percent of the Medicaid line item per diem rates for outpatient services, for counties that are at their 10 mill cap on ad valorem taxes.

B. 100 percent of the Medicaid rates for inpatient and outpatient hospital services, for counties that are not at their 10 mill cap on ad valorem taxes.

Due to legal requirements upon a hospital to provide emergency treatment, if the county will not agree to pay a higher rate of reimbursement, the hospital must accept 80 percent of the Medicaid rate from counties not at the 10 mill cap if the hospital wishes to participate in HCRA. However, in those situations concerning elective or non-emergency care requiring a prior agreement with the county, the hospital may deny such services if it is unwilling to accept the reimbursement rate offered by the county.

2-27 County/Hospital Agreement Notification Requirements: If a county enters into an agreement with a hospital to participate in the HCRA or to participate at a negotiated reimbursement rate other than the standard rate, it must provide the Agency with a copy of the agreement. Such agreements must be sent to the address specified in Chapter 1, Section 1-10,

within 30 days of the date the agreement is signed. A sample participation agreement is provided in Appendix E.

Record Maintenance and Retention

2-28 County Agency Records Requirements for Eligibility Determination: The county certifying agency responsible for eligibility determination must establish a case record for each applicant, using the applicant's social security number or an assigned pseudo-number as the case number. An application cannot be denied solely because an applicant does not have or refuses to furnish a Social Security number.

A. The case record must contain the following:

    1. Copy of the application;

    2. Copies of any verification obtained pertaining to income, assets, residency, spend-down provision eligibility, third party payors and eligibility for other programs;

    3. Copy of Notification of Eligibility;

    4. Copies of utilization review findings; and

    5. Copies of any documents pertaining to a request for a hearing regarding eligibility and the results of that hearing.

B. The county certifying agency must retain all case records for a period of three years from the date of the last action taken on the case.

2-29 Hospital Responsibilities for Record Retention: The hospital must establish a case record on each applicant for coverage under this program, using the applicant's Social Security Number, if possible, or a pseudo-number as the case number.

A. Each case record must contain the following:

    1. Copy of the application;

    2. Copies of any verification obtained pertaining to income, assets, residency, spend-down provision eligibility, third party payors and eligibility for other programs;

    3. Copy of any Notification of Eligibility received;

    4. Copies of utilization review findings (copies may be kept in the hospital's case record, financial record, or medical record); and

5. Copies of any documents pertaining to a request for an appeal or hearing regarding eligibility and the results of that hearing.

B. The hospital must retain each record for a period of three years from the date of the last action taken on the case.

2-30 Hospital Responsibilities for Claims Records: The hospital must establish and maintain a financial record to track and verify claims paid for each HCRA applicant.

A. Hospitals may combine these records with the applicant record established at the time of application, if it is administratively feasible.

1. It is recommended that the hospital use the same case number on the financial record as was used in the application record, if separate records must be kept.

2. The hospital must retain all financial records for a period of three years from the date the last payment for that individual is received.

B. The hospital's financial record must include the following:

1. A copy of the Notification of Eligibility;

2. A copy of the UB-04 claim;

3. Information on reimbursement made, including the separate tracking of spend-down provision applicants; and

4. Copies of hearing documents or other documentation on disputes regarding treatment, claim processing or reimbursement.

2-31 County Responsibilities for Claims Records: The county must also establish and maintain a **financial record** to track and verify claims paid for each HCRA applicant.

A. Counties must establish procedures to track the amount of inpatient and outpatient reimbursement received by each indigent patient in order to determine whether or not the patient has received reimbursement for the maximum number of days (45 days per county fiscal year) and to verify that the amount of outpatient reimbursement received is within the $1,500 maximum allowed by law.

1. Counties may combine these records with the application record established during the eligibility determination process, if administratively feasible.

2. It is recommended that the same case number be used on the financial record as was used in the application record, if separate records must be kept.

3. The county must retain all financial records for a period of three years from the date the last payment for that individual is received.

B. In addition, counties that are spend-down provision eligible counties must develop procedures to track the reimbursement and share of cost information for their spend-down provision applicants.

C. The county's financial record must include the following:

1. A copy of the Notification of Eligibility;

2. A copy of the UB-04 claim;

3. Information on reimbursement made, including the separate tracking of spend-down provision applicants to ensure that the county deducted the applicant's share of cost before reimbursing the hospital; and

4. Copies of hearing documents or other documentation on disputes regarding treatment, claim processing or reimbursement.