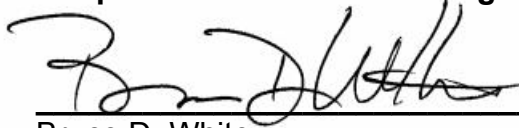


HOSPITAL POLICY AND PROCEDURE

TITLE: Hospital Care Assurance Program (HCAP)

APPROVED BY:



Bruce D. White
Chief Executive Officer



Michael V. Ambrosiani
Chief Financial Officer

EFFECTIVE DATE: November 2017

REVISED DATE:

DISTRIBUTION: All Hospital Personnel

RESPONSIBLE PERSONNEL: Patient Financial Services, Fiscal Services

POLICY: It is the policy of Knox Community Hospital to comply with the rules of the Expanded Hospital Care Assurance Program (HCAP), which became effective May 22, 1992. The HCAP rule (Rule) is listed at OAC 5160-2-07.17 in the Ohio Revised Code. Under this program Knox Community Hospital is required to provide free basic, medically necessary hospital-level services to individuals who are Ohio residents, (as defined by the Rule) are not recipients of the Medicaid program, and whose income is at or below the federal poverty limit. This program does not cover professional fees (physician bills).

A. DEFINITIONS:

1. "Basic, medically necessary services" are defined as any service that could be billed to Medicaid:
 - a. All inpatient and outpatient services covered under the Medicaid program in Chapter 5160-2 of the Administrative Code with the exception of transplantation services and services associated with transplantation. These covered services must be ordered by an Ohio licensed physician and the physician has clinical privileges, and where such services are permissible to be provided by the hospital under its certificate of authority granted under Chapters 3711. 3727. and/or 5119. of the Revised Code. Hospitals will be responsible for providing basic, medically necessary hospital – level services to those persons described in paragraph (B) of this rule.

2. "Third-party Payer" means any private or public entity or program that may be liable by law or contract to make payment to or on behalf of an individual for health care services. Third-party payer does not include a hospital.

B. Determination of eligibility

1. Under the HCAP program, a family is defined as "OAC 5160-2-07.17 (B)(1) 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 lives in the home. If the patient is under the age of eighteen the "family "shall include the patient, the patient's natural or adopted patents(s) (regardless of whether the live in the home), and the parent(s)' children, natural or adopted under the age of eighteen who live in the home. 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."
2. "Income" shall be defined as total salaries, wages, investment income, social security, disability payments, spousal support, pension payments , assets and cash receipts before taxes; cash receipts that reflect reasonable deductions for business expenses shall be counted for both farm and non-farm self-employment. Assets; include, nonresidential property, checking and savings account statements, investment income, etc. Income will be calculated by: Multiplying the person's or family's income by four, as applicable, for the three months preceding the date the hospital services were provided; by using the person's or family's income, as applicable, for the twelve months preceding the date the hospital services were provided. Child support will be calculated as income when the child for that support is the patient. Proof of income will be required at the time of application by the documentation stated in paragraph 2.
3. Documentation of income: If income cannot be verified by means above, a sworn statement or affidavit by patient or employer declaring the applicants income for the three or twelve months preceding the date of service will apply.
4. For outpatient hospital services, a hospital may consider an eligibility determination for ninety days from the date from the initial service date, during which a new eligibility determination need not be completed. Eligibility for inpatient hospital services must be determined separately for each admission, unless the patient is readmitted within forty-five days of discharge for the same underlying condition.
5. A complete application for the hospital care assurance program (HCAP) is required prior to determination of eligibility. The application must document income, family size and be signed by the patient/guarantor.

KNOX COMMUNITY HOSPITAL | MOUNT VERNON, OHIO

6. Knox Community Hospital will accept applications for HCAP for three years from the date of the first follow up notice sent to a patient.(OAC 5160-2-07.17) Any applications received for assistance for services past the three year limit will not be accepted.
7. Incomplete applications will be returned to the patient/guarantor, with a cover letter that indicates what information is needed to complete the application.
8. Completed applications will be reviewed for Medicaid eligibility of the applicant. Medicaid eligibility responses will be copied into the document imaging system along with the application and noted in the account. (In the event the patient is eligible for Medicaid on the date of service, the application will be denied due to the eligibility for Medicaid and Medicaid will be billed for the services) A letter will be sent to the patient/guarantor, advising them of the approval or denial for assistance.
9. Knox Community Hospital reserves the right to request applicants to the HCAP program to submit an application for Medicaid, if it appears from the completed HCAP application that the patient would qualify and is only necessary if there is no other source of payment (i.e. Medicare). An application for Medicaid, if approved, benefits the patient by providing coverage for services outside of hospital level services.
10. In order to be in compliance with the requirements of the HCAP program, the hospital has adopted the following procedures:
 - a. Posting of signs in the Financial Counselors Office, Central Registration, including the Pavilion and the Emergency Department.
11. The wording of the signs are as follows:
 - a. NOTICE: MEDICAL CARE FOR THOSE WHO CANNOT AFFORD TO PAY. Knox Community Hospital is required to provide basic medically necessary hospital level services without charge to individuals with incomes at or below the federal poverty limit. If you are not able to pay for the care you receive, contact the Financial Counselors Office (FC) in this hospital.
 - b. A written notice advising of available assistance and the application requirements is enclosed with each itemized bill of patients. The written notification is an "Application for Care Assurance Program" which the patient may complete and return to Financial Counselors office.

PREPARED BY: Financial Counselor Team Lead, VP of Finance, Director of Patient Access and Director of Patient Financial Services.