Subject:	Department:	Policy #	Rev.
OHIO HOSPITAL CARE ASSURANCE (HCAP) POLICY	**PATIENT FINANCIAL SERVICES**	**HCAP-01**	DRAFT 2/14/11 8/1/2012

The Cleveland Clinic Foundation and its hospital affiliates in the Cleveland Clinic Health System (collectively CCHS) are participants in Ohio's Hospital Care Assurance Program (HCAP). In compliance with HCAP, CCHS offers basic, medically necessary hospital-level services free of charge to qualified individuals. This HCAP policy should be read to comply with Ohio Revised Code § 5112.17 and Ohio Administrative Code § 5101:3-2-07.17. See Appendix A for defined terms.

1. Eligibility. A patient is eligible for HCAP if the patient is:

   a. not a recipient of the Medicaid program;

   b. a resident of Ohio;

   c. a current recipient of the disability assistance (DA) program, or its successor program, or the person's individual or family income is at or below the current federal poverty income guideline issued by the Department of Health and Human Services and in effect at the date of service for awards of assistance under this policy ("FPG").

2. Application Process. Patients who wish to be considered under HCAP must complete an application, provide proof of income, and cooperate with CCHS's efforts to establish eligibility and to determine any potential third-party resources that may be available. CCHS does require an individual to apply for eligibility under Medicaid before the hospital processes an HCAP application. Once the patient completes the Medicaid application, the HCAP application will be processed.

   a. *Application*. A complete application for HCAP is required prior to determination of eligibility. The application shall document income, family size and Medicaid eligibility. The patient or a legal representative is required to sign the application. An unsigned application may be acceptable if the patient is physically unable to sign the application or does not live in the vicinity of the hospital and is unable to return a signed application by mail. In these situations, a CCHS representative may complete all questions on the application, sign it, and document why the patient is unable to sign the application. See Appendix B for a copy of the current application.

   b. *Income Documentation Requirements*. CCHS requires appropriate income eligibility documentation. Documentation may include pay stubs, bank statements or a letter from the applicant's employer. If this is not available, a completed application, signed by the patient or his/her authorized representative, or an application completed by a CCHS representative, which is clearly documented to indicate why the patient or authorized applicant was not able to sign, may be used.

c. *Income Calculation.* Income will be calculated by:

i. Multiplying by four the person's or family's income, as applicable, for the three months preceding the date hospital services were provided; and

ii. Using the person's or family's income, as applicable, for the twelve months preceding the date hospital services were provided.

Income shall be calculated using both methodologies and the result that is most beneficial for the patient to support eligibility for free care shall be used. If the two methodologies result in conflicting eligibility determinations, CCHS will use the one that allows the patient to qualify. If the patient can only document one of the methodologies, the application may be approved based on the available documentation.

d. *Disability Assistance Eligibility.* CCHS requires appropriate eligibility documentation for DA patients. A current DA card is required. DA cards for months prior to or after the reported month of service are not acceptable documentation.

3. Notice. CCHS shall post notices in the admissions areas, business offices and places where patients pay their bills, and emergency rooms that specify the rights of patients with incomes at or below the federal poverty guideline to receive, without charge to the individual, basic, medically necessary hospital-level services at the hospital. Posted notices must: 1) be in plain language; 2) specify the rights of these patients to receive without charge, basic, medically necessary hospital-level services; 3) be in English and other languages that are common to the population of the area serviced; and 4) be clearly readable at a distance of twenty feet or the expected vantage point of the patrons. CCHS shall make reasonable efforts to communicate the contents of the posted notice to persons it has reason to believe cannot read the notice.

4. Billing. CCHS may bill any third-party payer that has a legal liability to pay for services rendered under HCAP. CCHS may also bill Medicaid if the individual becomes a recipient of the Medicaid program. Finally, CCHS may bill individuals for services if all of the following apply:

a. CCHS has an established post-billing procedure for determining the individual's income and canceling the charges if the individual is found to qualify for services under the provisions of this rule;

b. The initial bill, and at least the first follow-up bill, include a written statement that: 1) explains that individuals with incomes at or below the federal poverty level are eligible for services without charge; 2) specifies the federal poverty guidelines for individuals and families of various sizes at the time the bill is sent; and 3) describes the post-billing procedure for determining the individual's income and canceling the charges if the individual is found to qualify for services under the provisions of this rule. This statement may appear on the back of the bill, but it must be referenced on the front of the bill as well.

5. Reporting. CCHS shall collect and report to the Ohio Department of Job and Family Services information on the number and categorical identity of persons served under HCAP.

   In addition to the HCAP program, CCHS provides financial assistance to uninsured patients at family income levels up to four times the FPG. CCHS financial assistance applies to both hospital level services and physician services provided by CCHS employed physicians (see CCHS Policy # ___ re: Financial Assistance).

6. Effective Date. This Policy is effective on 03-01-2011.

APPENDIX A.

As used in this policy:

1. "Basic, medically necessary hospital level services" means all inpatient and outpatient services covered under the Medicaid program in Ohio Administrative Code § 5101:3-2 with the exception of transplantation services and services associated with transplantation. These covered services must be ordered by an Ohio licensed physician and delivered at a hospital where the physician has clinical privileges and where such services are permissible to be provided by the hospital under its certificate of authority.

2. "Family" includes the patient, the patient's spouse (regardless of whether they live in the home), and all of the patient's children, natural or adoptive, 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 adoptive parent(s) (regardless of whether they live in the home), and the parent(s)' children, natural or adoptive under the age of eighteen who live in the home.

3. "Income" means total salaries, wages, and cash receipts before taxes; receipts that reflect reasonable deductions for business expenses shall be counted for both farm and non-farm self-employment.

4. "Resident of Ohio" means a person who is living in Ohio voluntarily and who is not receiving public assistance in another state. The Ohio Department of Job and Family Services allows hospitals to include temporary residents, such as students or migrant workers, and patients who are temporarily residing with in-state relatives. Out-of-state patients who are on vacation in Ohio, or any patient who has come to Ohio solely to receive medical care do not meet the residency requirements. Illegal aliens may also meet this residency requirement.

5. "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.