Ohio Administrative Code

Rule 5160-2-07.17 Provision of basic, medically necessary hospital-level services.

Effective: June 25, 2015

Under the provisions of section 5168.14 of the Revised Code, each hospital that receives payment under the provisions of Chapter 5168. of the Revised Code, shall provide, without charge to the individual, basic, medically necessary hospital-level services to the individual who is a resident of this state, is not a recipient of the medicaid program and whose income is at or below the federal poverty line. Residence is established by a person who is living in Ohio voluntarily and who is not receiving public assistance in another state. Current recipients of the disability assistance (DA) program as defined in Chapter 5115. of the Revised Code or its successor program, qualify for services under the provisions of this rule.

(A) Definitions.

(1) "Basic, medically necessary hospital level services" are defined as 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 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 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.

A person is eligible for basic, medically necessary hospital-level services under the provisions of this rule if the person is a current recipient of the DA program or its successor program, or the person's

individual or family income is at or below the current poverty guideline issued by the department of health and human services (available at: http://www.medicaid.ohio.gov/FOROHIOANS/FinancialRequirements.aspx). The current poverty guideline that applies to the individual or family is calculated using either of the methods described in paragraphs (B)(2)(a) and (B)(2)(b) of this rule on the date these services were provided.

(1) For purposes of this rule, a "family" shall include 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. 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. If the patient is the child of a minor parent who still resides in the home of the patient's grandparents, the "family" shall include only the parent(s) and any of the parent(s)' children, natural or adoptive, who reside in the home.

(2) "Income" shall be defined as total salaries, wages, 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. Income will be calculated by:

(a) Multiplying the person's or family's income by four, as applicable, for the three months preceding the date hospital services were provided;

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

(3) For outpatient hospital services, a hospital may consider an eligibility determination to be effective for ninety days 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. Eligibility for recipients of the DA program or its successor program must be verified on a monthly basis.

(4) A complete application for the hospital care assurance program is required prior to determination of eligibility. Each hospital shall develop an application that, at a minimum, must document income, family size and eligibility for the medicaid program. The patient or a legal representative is required to sign the application. An unsigned application can be deemed 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, the hospital representative shall complete all questions on the application, sign the application, and must document why the patient is unable to sign the application.

(5) The hospital shall accept application for services without charge until three years from the date of the follow-up notice, as described in paragraphs (C)(2) and (C)(3) of this rule, has elapsed.

(6) Applicants shall 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.

(7) Nothing in this rule shall be construed to prevent a hospital from assisting and/or requiring an individual to apply for medicaid before the hospital processes an application under this rule.

(C) Billing requirements.

Hospitals may bill any third-party payer that has a legal liability to pay for services rendered under the provisions of this rule. Hospitals may bill the medicaid program in accordance with Chapter 5164. of the Revised Code and the rules adopted under that chapter for services rendered under the provisions of this rule if the individual becomes a recipient of the medicaid program. Hospitals may bill individuals for services if all of the following apply:

(1) The hospital 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;

(2) The initial bill, and at least the first follow-up bill, is accompanied by a written statement that does all of the following:

(a) Explains that individuals with income at or below the federal poverty guidelines are eligible for services without charge;

(b) Specifies the federal poverty guideline for individuals and families of various sizes at the time the bill is sent; and

(c) Describes the procedure required by paragraph (C)(1) of this rule.

(3) If the written statement as described in paragraph (C)(2) of this rule is printed on the back of the hospital's bill or data-mailer, the hospital must reference the statement on the front of the bill or data-mailer; and

(4) Notwithstanding paragraph (B) of this rule, a hospital providing care to an individual under the provisions of this rule is subrogated to the rights of any individual to receive compensation or benefits from any person or governmental entity for the hospital goods and services rendered.

(D) Notice requirements.

Each hospital that receives payment under Chapter 5168. of the Revised Code shall post notices in appropriate areas of their facility, which include the admissions areas, the business office, and the emergency room; the posted notices are not limited to these areas. The posted notices must specify the rights of persons with incomes at or below the federal poverty line to receive, without charge to the individual, basic, medically necessary hospital-level services at the hospital.

Posted notices must contain all of the following in order to comply with the requirement as described in this paragraph:

(1) At a minimum, the posted notices must specify the rights of these individuals to receive without charge, basic, medically necessary hospital-level services;

(2) The wording of the posted notice must be clear and in simple terms understandable by the population serviced;

(3) Posted notice must be printed in English and other languages that are common to the population of the area serviced;

(4) The posted notice must be clearly readable at a distance of twenty feet or the expected vantage point of the patrons; and

(5) The facility shall make reasonable efforts to communicate the contents of the posted notice to persons it has reason to believe cannot read the notice.

(E) Documentation requirements.

Each hospital shall establish and maintain a written policy outlining its internal policy for administration of the hospital care assurance program in compliance with this rule and with rule 5160-2-23 of the Administrative Code. Each hospital may change its written policy as needed, but policy changes may not be implemented retroactively. The written policy shall include, but is not limited to, the following:

(1) Procedure for taking applications and a copy of the current application in use as described in paragraph (B) of this rule; and

(2) Procedure for eligibility determination including the determination of family size and determination of income. If the hospital requires verification of income other than the application, the written policy should describe what constitutes acceptable income documentation.

(F) Reporting requirements.

Each hospital shall collect and report to the department information on the number and categorical identity of persons served under the provisions of this rule.

(1) This information will be reported on the ODM 02930, schedule F, which must be submitted annually along with a certification of the accuracy of this reported data as required by rule 5160-2-23 of the Administrative Code. The ODM 02930 and instructions for completion are available on the

department's website.

(2) The use of estimation methods to determine amounts for charges related to non-hospital level services or to determine the health insurance status of patients charges on patient accounts is not permitted.

(3) Each hospital shall maintain, make available for department review and provide to the department on request, any records necessary to document its compliance with the provisions of this rule, including:

(a) Any documents, including medical records of the population served, from which the information required to be reported on the ODM 02930 was obtained;

(b) Accounts that clearly segregate the services rendered under the provisions of this rule from other accounts;

(c) Copies of the determinations of eligibility under paragraph (B) of this rule; and

(d) A copy of the disability assistance card or other evidence of eligibility for any person who is a recipient of the DA program or its successor program at the time the services defined in paragraph (A) of this rule were delivered.

(4) Hospitals must retain these records for a period of six years from the date of receipt of payment based upon those records or until any audit initiated within the six year period is completed.

(G) This rule in no way alters the scope or limits the obligation of any governmental entity or program, including the program awarding reparations to victims of crime under sections 2743.51 to 2743.72 of the Revised Code and the program for medically handicapped children established under section 3701.023 of the Revised Code, to pay for hospital services in accordance with state or local law.