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 Shared County and State Health Care Program (SCS) and HCRA 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 either this program or the SCS, if the SCS is state funded. Currently the SCS program is not state funded. In the event that SCS is funded, the above statement applies.

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.