FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for All Floridians

HCRA

The Florida Health Care Responsibility Act

Enacted in 1977

Presented by:

Kirsten Barrett, Bureau of Central Services

Phone: (850) 412-4333 Fax: (850) 414-6912

Email: hcra@ahca.myflorida.com

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HCRA

- Governed by:
  - Chapter 154, Part IV, ss. 154.301-154.331, Florida Statutes;
  - Chapter 59H-1, Florida Administrative Code; and
  - HCRA Handbook

HCRA

- Basic Purpose
  - The HCRA program is used as a payment mechanism between counties and hospitals:
  - Counties reimburse out-of-county participating hospitals for emergency services (inpatient and outpatient) provided to county indigents.
  - Counties can reimburse in-county (up to ½ of its total HCRA funds) participating hospitals for emergency services (inpatient and outpatient) provided to county indigents. The current counties are:
    - Bradford, Calhoun, Hamilton, Hardee, Holmes, Levy, Madison, Suwannee, Taylor, Union, Volusia and Washington.
  - Counties can pre-approve non-emergency care for services not available in-county. The following counties have written pre-authorization and pre-approval procedures on file with the Agency:
    - Brevard, Flagler, Hernando, Nassau, St. Lucie, and Seminole.

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- Funding
  - All Florida counties are required to participate.
  - 100% funded by each county. Each county has a maximum fiscal liability of $4 per capita.
    - Counties with a population of 100,000 or less can reduce funding by the:
      - Number of persons living in certain institutions; and by the
      - Number of active-duty military personnel residing in the county.

      (Baker, Bradford, Glades, Gulf, Hardee, Holmes, Jefferson, Liberty, Madison, Nassau, Taylor, Union, and Wakulla County(s) have elected to participate in the reduction)
  - All HCRA funds are only to be used to reimburse participating hospitals for qualified indigent emergency services or pre-approved non-emergency care.
  - For the counties who have designated up to ½ of its HCRA funds and chosen to provide in-county reimbursement, funds allocated for out-of-county reimbursement cannot be used to supplement in-county funds.

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- Participating Hospital Criteria
  - In order to participate in the HCRA program, the hospital must meet 2% overall charity care obligation. Non-teaching hospitals certified by the Agency for Health Care Administration (Agency) must also have either:
    - A formal signed agreement with the applicant's county of residence to treat that county's indigent poor; or
    - Have 2.5% of its uncompensated charity care generated by out-of-county residents.
  - Hospital participation is voluntary. Participating hospitals shall have its billing systems in place to accommodate DRGs and EAPGs; therefore, the county shall not be liable for payment of treatment of a certified resident who is a qualified indigent patient or spend-down provision eligible patient, until such time as that hospital has met its obligation to be able to provide the necessary information to the counties required to calculate the rate of reimbursement.

    Questions regarding the hospital eligibility requirements and completing the charity care report should be directed to the Agency's Financial Analysis Unit with the Bureau of Central Services.

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- General Roles of HCRA
  - **Participating Hospitals** process applications and bill for services rendered.
  - **Counties** determine eligibility and make payments to the hospitals.
  - **Agency** oversees day to day administration of the program on a statewide level.

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- Responsibilities of the **Applicants** (including recipients and/or designated representatives)
  - Complete and sign the HCRA application,
  - Sign the Applicant's Rights and Responsibilities form,
  - Assist in eligibility determinations by providing accurate sources of information and verification in regards to the applicant's residency, income, assets, and other eligibility requirements (should it be determined that fraud was committed or incorrect information was provided intentionally which resulted in an inappropriate eligibility determination, the applicant will be responsible for repaying any amounts paid on their behalf),
  - Keep appointments (failure to do so, without good cause, may result in the application being denied), and
  - Spend-down provision applicants must pay the amount of their share of cost to the hospital.

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- Responsibilities of the **Participating Hospitals**
  - Assist applicants in completing the HCRA application,
  - Screen applicants and initiate the eligibility determination process,
  - Advise applicant of their rights and responsibilities,
  - Notify county of individual who may qualify by submitting completed application and supporting documentation,
  - Upon receipt of applicant approval, submit claims to county,
  - Collect applicant's spend-down share, when applicable, and
  - Keep case record on applicant for 3 years.

Hospital personnel responsible for eligibility determinations and claims processing in regards to the HCRA program must have an email address and internet access in order to receive any HCRA updates, forms and/or other information.

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- Responsibilities of the **County**
  - Primary responsibility for determining residency and eligibility for applicants using the criteria prescribed by rule (if sufficient supporting documentation is not provided by the Hospital to determine eligibility, the county must request it from the applicant) and notify the applicant and hospital of approval or denial of application,
  - Advise applicant of their rights and responsibilities,
  - Pay participating hospital for approved claims,
  - Notify the Agency and participating hospitals in writing if maximum financial obligation has been reached. Certification must be sent to the Agency within 60 days of the date the maximum financial obligation has been reached,
  - Notify the Agency of any change to its decision to provide in-county reimbursement within 45 calendar days following the start of a new county fiscal year,
  - Timely submit the Monthly Caseload & Appeals and Quarterly Financials reports to the Agency,
  - Provide the Agency with updated contact information for eligibility determination and claims processing personnel, and
  - Keep case record on applicant for 3 years.

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- Responsibilities of the **Agency**
  - Develop forms and reports, provide training and technical assistance, interpret policy, monitor, receive and maintain reports, etc. on a statewide level to counties and participating hospitals,
  - Determine eligibility if county is unable to do so for circumstances beyond their control, and
  - Update and amend the rules as necessary.

The notifications listed below will be posted to the HCRA website. If you are unable to find them, contact the HCRA liaison.

March 1st

- Determine the maximum amount of the county's financial obligation for the fiscal year and notify each county of such.
- Update Income and Asset Limits

July 1st

- Notify hospitals and counties of the Medicaid inpatient and outpatient reimbursement rates for hospitals.

September

- 15th - Provide a list of eligible hospitals and their dates of eligibility for the fiscal year to those hospitals and to the counties.
- Provide an updated list of county contacts and participating hospital contacts.

October

- Provide updated automated report templates for the fiscal year.

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- Covered Services at Participating Hospitals
  - **Emergency outpatient up to $1,500 per applicant per year**
    - 100% of the hospital's Medicaid reimbursement rate
  - **Emergency inpatient up to 45 days per applicant per year**
    - 100% of the hospital's Medicaid reimbursement rate; or
    - 80% of the hospital's Medicaid reimbursement rate if the county was at its 10 mill cap as of 10/1/1991. Those counties are:
      - Calhoun, Dade, Dixie, Gadsden, Gilchrist, Hardee, Holmes, Jackson, Jefferson, Lafayette, Liberty, Okeechobee, Sumter, Union, Wakulla and Washington.
  - **Pre-approved elective and non-emergency services (including follow-up care) if not available in county of residence**
    - Same reimbursement rates as mentioned above
  - **Diagnoses or procedures not covered by Medicaid are not covered by the HCRA program**

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- ## Hospital Reimbursement Rates
  - Links to the Medicaid inpatient diagnosis-related groups (DRG) and the Medicaid outpatient enhanced ambulatory patient grouping (EAPG) reimbursement calculators are posted to the Agency's HCRA website each July.

The 2011 Legislature mandated that, instead of semiannually, hospital rates are to be calculated annually effective July 1 of each year.

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.

The 2016 Legislature mandated the Agency to implement a new outpatient payment method utilizing enhanced ambulatory patient groups (EAPG). EAPG transitions hospital outpatient reimbursement from a cost-based per diem per line item to a budget neutral manner by categorizing services and procedures into groups for payment based on clinical information present on an outpatient claim. They are designed to pay for facility time and resources. The EAPG payment system was effective July 1, 2017.

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- Application Process
  - The participating hospital is responsible for screening applicants and initiating the application process. The participating hospitals must:
    - Determine if the patient is a resident of the county in which the hospital is located or a resident of another county in Florida; ****Please note that a declaration of domicile (which is mainly used for homeless applicants) should be used as a last resort and must be accepted ONLY in the absence of any other acceptable residency documentation as listed in Chapter 5, Section 9 of the Handbook.*
    - Review any health insurance or third party coverage, check to see if patient is eligible for Medicaid, has Medicare or is eligible for other state or federal programs providing hospital care;
    - Determine if patient can pay for the services rendered; and
    - Submit the application and supporting documentation to the county of residence via certified mail within 30 days from the date of admission or receipt of emergency treatment. (Failure to do so may cause the application to be denied by the county.)

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- ## Eligibility Determination Process
  - The county has the primary responsibility for determining residency and eligibility of applicants and must do so within 60 days of receipt of an application from the participating hospital using the criteria prescribed by rule. The county verifies:
    - Timeliness of the application submission,
    - Residency,
    - Assets,
    - Citizenship (if not a U.S. citizen, alien registration number must be provided),
    - Living address/shelter (some examples of public institutions are a correctional institution; holding facility for prisoners; arrested or detained awaiting disposition of charges; held under court order as a material witness or juvenile; or a patient in a state mental hospital),
    - Income, and
    - If appropriate, determine if applicant is eligible for HCRA through the spend-down provision, including applicant's share of cost.

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- Residency. Acceptable residency documentation include:
  - Driver's license.
  - Mortgage, lease, rental receipt or letter from the landlord.
  - Proof of home ownership.
  - Water, electric or other public utility bill in the name of the applicant or spouse for service to a residential address within the county.
  - A state, county or federal document mailed to the applicant to an address within the county.
  - Vehicle registration in the name of the applicant or spouse to the residential address within the county.
  - Voter registration.
  - Proof of children enrolled in public schools.
  - Recent historical record of residence documented through a county department's case record.
  - Other documents of equal weight as those above that verify an applicant's residency.
  - **In the absence of any of the above documentation**, a declaration of domicile must be accepted.

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- Assets:
  - The county must review the applicant's assets to determine if they are within the HCRA limits. HCRA uses the same asset limits as those used for the Medically Needy program.
  - In order for an asset to be considered, it must first be "available". An asset is "available" if the applicant or a member of the family unit has the right, authority or power to liquidate the property or his share of the property.
  - Some assets are excluded from being considered as "available." For this, HCRA uses the same asset guidelines used for determining eligibility for SSI, unless otherwise indicated in the handbook.

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Assets to be considered:

1. Checking and saving accounts.
2. The equity value of real property other than the homestead.
3. The cash surrender value of life insurance, if the combined face value of all policies owned by the family unit exceeds $1500.
4. Additional automobiles or motor vehicles.
5. Recreational vehicles.
6. Trusts.
7. Stocks, bonds and other investment assets.

Assets NOT to be considered:

1. One homestead.
2. Household furnishings.
3. One automobile in operating condition, regardless of value.
4. Clothing.
5. Tools used in employment.
6. Cemetery plots, crypts, vaults, mausoleums and urns.
7. Produce and animals raised for the applicant's personal home consumption.

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– Income:

- The county must review the applicant's income for the month prior to the date of admission or treatment. The county must require additional income verification for the 12 month period prior to the time of determination if the income received for the month prior to admission or treatment is not representative of the family's current income situation and if it is in the applicant's best interest to do so.
- For the purposes of HCRA, there are no "no income" applicants (unless the applicant is homeless). All applicants have income in the sense that somebody is providing for them and the Monthly Household Expense Calculation Form from the website should be completed in these situations in order to determine their income contributions.

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- The county must determine who is in the applicant's family unit in order to determine if the family unit's gross income is within the HCRA income standards. A family unit is defined as one or more persons residing together in the same household whose needs, income and assets are included in the household budget.
  - **Excluded** are: roomers and boarders. A roomer is a person for whom a payment is made for a room and who is not the spouse or partner of the landlord. A boarder is a person for whom a payment is made for a room and meals and who is not the spouse or partner of the landlord.

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Included Income

a. Gross wages and salary.

b. Child support.

c. Alimony.

d. Unemployment compensation.

e. Worker's Compensation.

f. Veterans' pension.

g. Social Security. (this could indicate eligibility for Medicaid or Medicare)

h. Pensions or annuities.

i. Dividends. Certifying agency verifies by a copy of the check or a statement from the payor.

j. Interest on savings or bonds.

k. Income from estates or trusts.

l. Net rental income or royalties including rent received from any roomers or boarders.

m. Net income from self-employment.

n. Contributions from any source.

Excluded Income

a. Food stamps.

b. Income tax refunds.

c. A child's earnings, such as from an after school job.

d. Student financial aid, if it is for tuition, books, supplies, and school fees.

e. The income of any roomers or boarders.

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- Spend-Down Provision Eligibility:
  - 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.
  - If the applicant, who is otherwise eligible, is a resident of a county that was not at its 10 mill cap on ad valorem taxes as of October 1,1991 and their income appears to be between 100% and 150% of the federal poverty level, they may be eligible for HCRA reimbursement provided their eligible hospital expenses exceed their share of cost.
  - The county must have the charges (or an estimate) from the participating hospital to determine the applicant's eligibility and estimated share of cost.

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- Claims Process
  - The participating hospital has 6 months from the date it received the Notice of Eligibility (NOE) to submit the completed claim form to the county of residence for payment.
  - The county has 90 days from the date it received the claim and copy of NOE to complete its adjudication and reimburse the participating hospital when appropriate. (If the county does not reimburse the participating hospital within the required timeframe, it may submit the claim directly to the State Comptroller.) All charges for dates of service rendered during a fiscal year are to be paid by the county from the funds obligated to the HCRA program for that same designated fiscal year.
  - The payment made to the participating hospital is considered as payment in full, except for non-covered services and for the spend-down provision applicant's share of cost. If, after a county has paid a claim, the participating hospital receives payment from a third party for the same services, it must refund the HCRA funds to the county within 30 days of receipt of such payment.

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- Appeals Process
  - An appeal may be requested when there is a denial of a claim or an application within 90 days from the date of the Notification which denies eligibility or reimbursement. Every effort should be made by the involved parties to resolve the issue before an appeal is made.
  - Appeals may only be requested by the participating hospital or the county.

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- Application timeline in review:
  - The participating hospital must submit the application to the county via certified mail within **30 days** of the admission date.
  - The county must review and determine eligibility and mail the NOE within **60 days** of receiving application.
  - The participating hospital must submit the claim for approved applicants within **6 months** from the date on the NOE for payment.
  - The county must review and pay/deny the claim within **90 days** from receiving it.
  - Any appeals must be requested within **90 days** from the date of the denial for eligibility or reimbursement.

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- REQUIRED Reporting to the Agency
  - One of the responsibilities of the counties is to timely submit the **Monthly Caseload and Appeals Report** and the **Quarterly Financial Report**. Failure to timely submit the required reports may result in the Agency's legal department and County Commissioner's involvement. To help ensure accuracy and simplify the reporting process, the counties are to use the automated report templates found on the HCRA website.

HCRA

– Monthly Caseload and Appeals Report

- Documents caseload activity on application approvals and/or denials and appeals received and/or resolved on a monthly basis.
- Any applications or appeals pending at the end of the report month carry over to the following month.
- Due by the 15th of the following month. (i.e. April's report will be due on or before May 15th) Should the 15th fall on a holiday or weekend, the report is due the next business day.

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– Quarterly Financial Report

- Documents the expenditure amounts and number of claims paid and/or denied for the specified quarter and provides a running total for the fiscal year to date. The total expenditures should equal the amount from the total number of claims **paid** during that specific quarter, regardless od service date(s). The number of claims denied should only be reported on claims received and denied upon receipt (pass deadline, not a covered service, etc.) from an approved NOE.
- Supporting documentation should include a legible copy of the hospital claim indicating the allowable amount through HCRA, a copy of the application, a copy of the NOE and proof of payment for each claim paid during that quarter. Appropriate proof of payment would include a copy of the reimbursement check, a ledger with the check information (#, date and amount), etc. Copies of purchase orders or requests for payment, etc. are not acceptable.
- Due within 30 days from the end of each county fiscal year quarter. (i.e. the 3rd quarter report will be due on or before July 30th) Should the deadline fall on a holiday or weekend, the report is due the next business day.

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– Affects of the Affordable Care Act ("Obama Care")

- Applicants may not be required to file a tax return because of income, and those below 100% of the federal poverty level are not required by the individual mandate to have insurance, there will still be many people uninsured in Florida.
- There is nothing in the Affordable Care Act (ACA) that addresses this. At this time, the Agency's assumption is that the HCRA program is not directly affected since it is a state law and not tied to any federal funds. Unless specifically stated otherwise, the ACA does not counter any existing state laws.

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- For additional information and forms:
  - Website
    - http://www.ahca.myflorida.com/MCHQ/Central_Services/Financial_Ana_Unit/HCRA/index.shtml
  - Handbook
    - http://www.ahca.myflorida.com/MCHQ/Central_Services/Financial_Ana_Unit/HCRA/hcrahb.shtml