Ohio Administrative Code

Rule 5160-2-17 Provision of basic, medically necessary hospital-level services.

Effective: July 28, 2022

(A) In accordance with section 5168.14 of the Revised Code, each hospital that receives payment under the provisions of Chapter 5168. of the Revised Code, will 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.

(B) For purposes of this rule, the following definitions apply:

(1) "Basic, medically necessary hospital level services" are 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 are to be ordered by a practitioner of physician services and delivered at a hospital where the provider 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 5119. of the Revised Code. Hospitals will be responsible for providing basic, medically necessary hospital-level services to those persons described in paragraph (C) of this rule.

(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" will 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 patient is the child of a minor parent who still resides in the home of the patient's grandparents, the "family" includes only the parent(s) and any of the parent(s)' children, natural or adoptive, who reside in the home.

(3) "Income" is defined as total salaries, wages, and cash receipts before taxes; cash receipts that reflect reasonable deductions for business expenses will be counted for both farm and non-farm self-

employment.

(4) "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.

(C) Determination of eligibility.

(1) A person is eligible for basic, medically necessary hospital-level services under the provisions of this rule if the person's individual or family income is at or below the current poverty guideline issued by the department of health and human services, as published at http://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/ and effective on the date they were published in the Federal Register. The current poverty guideline that applies to the individual or family is calculated using either of the methods described in paragraphs (C)(2)(a) and (C)(2)(b) of this rule on the date of inpatient admission or outpatient service.

(2) 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 will proceed with the available income information. 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 is determined separately for each admission, unless the patient is readmitted within forty-five days of discharge for the same underlying condition.

(4) A complete application for the hospital care assurance program is necessary prior to

determination of eligibility. Each hospital will develop an application that, at a minimum, documents income, family size and eligibility for the medicaid program. The patient or a legal representative will need 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 should complete all questions on the application, sign the application, and document why the patient is unable to sign the application. A hospital may create policies, in accordance with paragraph (F) of this rule, that allow for the completion and signature of an application electronically provided there is reasonable assurance that it is the patient or the patient's legal representative who signs the application.

(5) A hospital system may create policies, in accordance with paragraph (F) of this rule, that allow for all hospitals in the system to use a single approved application provided that the provisions of paragraph (C)(3) of this rule are maintained.

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

(7) Applicants will 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.

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

(D) Billing of claims.

(1) Claims should be billed in accordance with section 5168.14 of the Revised Code and this rule.

(2) If the written statement as described in division (B)(2) of section 5168.14 of the Revised Code is printed on the back of the hospital's bill or data-mailer, the hospital will reference the statement on the front of the bill or data-mailer.

(E) Notices.

(1) Each hospital that receives payment under Chapter 5168. of the Revised Code will post notices in appropriate areas of their facility, including but not limited to the admissions areas, the business office, and the emergency room. The posted notices will 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 will include all of the following in order to comply with the criteria as described in this paragraph:

(a) At a minimum, the rights of individuals to receive without charge, basic, medically necessary hospital-level services;

(b) Clear wording in simple terms understandable by the population serviced;

(c) Information printed in English and other languages that are common to the population of the area serviced;

(d) Print that is clearly readable at a distance of twenty feet or the expected vantage point of the patrons.

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

(F) Documentation.

Each hospital will 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 cannot be implemented retroactively. The written policy will 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 (C) of this rule; and

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

(G) Reporting.

(1) Information regarding the number and identity of individuals served pursuant to this rule should be reported on the ODM 02930, schedules F and J, which is submitted annually along with a certification of the accuracy of this reported data as described 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 patient charges on patient accounts is not permitted.

(3) Each hospital will maintain, make available for review, and provide to the department or the department's disproportionate share hospital auditor 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 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; and

(c) Copies of the determinations of eligibility under paragraph (C) of this rule.

(4) Hospitals will 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.

(H) 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.