Ohio
Department of Medicaid
John R. Kasich, Governor
John B. McCarthy, Director

May 22, 2015

«Greeting» «FirstName» «LastName»
«ProviderName»
«Address»
«City» «State», 43952

REGARDING: Hospital Care Assurance Program (HCAP) 2014 for provider «ProvNum». This is a combined Preliminary and Final Assessment Letter and is the only notice you will receive for this year's program.

Dear «Greeting» «LastName»,

The purpose of this letter is to notify you of the preliminary assessment amount to be paid for this year's Hospital Care Assurance Program. **The preliminary assessment becomes the final assessment, 14 days from the mailing date of this letter, unless a reconsideration request is submitted**.

Included in the last page of this letter, you will find additional data elements from your SFY 13 interim settled Medicaid Cost Report which are used in the 2014 HCAP calculations.

Adjusted Total Facility Cost (ATFC)*:	**«ATFC»**
Your facility's total 2014 annual assessment is:	**«Assessment»**
Your assessment is to be paid in two installments of:	**«Payment»**
First Installment Invoice Number:	**HCA141«Provnum»**
Second Installment Invoice Number:	**HCA142«Provnum»**

*Adjusted Total Facility Cost = total facility cost minus skilled nursing costs, home health agency costs, hospice costs, ambulance service costs, DME rented costs, DME sold costs, and other non-hospital costs as determined by the department.

The methodology for calculating the assessment is as follows: hospitals with adjusted total facility costs that are less than $216,372,500 are assessed 0.8401502% of their adjusted total facility cost. Hospitals with adjusted total facility costs that are greater than $216,372,500 are assessed 0.8401502% of the first $216,372,500 and 0.663% of any costs in excess of $216,372,500. Please be advised that Ohio Administrative Code Rule 5160-2-08.1 may be amended to change the assessment amount and methodology.

50 W. Town Street, Suite 400
Columbus, Ohio 43215
medicaid.ohio.gov

Per chapter 5160-2-08.1 of The Ohio Administrative Code, hospitals may request a reconsideration of the assessment amount. The request for reconsideration must be in writing, with documentation to support your position. This material should also be emailed or faxed to:

Roy Sutton
Ohio Department of Medicaid
Rate Setting & Cost Settling Unit
P.O. Box 182709
Columbus, OH 43218-2709

Fax: 614-752-2349
Roy.Sutton@Medicaid.Ohio.gov

This information must be **RECEIVED BY June 8, 2015 AT 10:00 a.m.** Materials received after 10:00 a.m. on June 8, 2015 will not be accepted.

Hospital Care Assurance Program (HCAP): 2014 ASSESSMENT DUE DATES.

We must receive the first installment on or before **June 12, 2015** and the second installment on or before **June 26, 2015. The due dates shown are the dates when the assessments must be received (not transmitted).** Failure to make the assessment payments by the specified due date, will delay program disbursements to all hospitals.

Your payment **must** be submitted via EFT. Please EFT your payments to the following bank routing address:

EFT Routing Address and accompanying information:
Routing Number: ABA# 041001039
Key Bank- To Credit State of Ohio Regular
Account#: 014511001050
In reference field: ODM – HCAP 2014 invoice # (see table above)

Contact: revenue@medicaid.ohio.gov

Special Instructions: If you desire to test this routing address, please use an amount of $0.01.

IMPORTANT: PLEASE **DO NOT** COMBINE YOUR **HCAP** AND **HOSPITAL FRANCHISE FEE PAYMENTS**.

New Instructions: Please format the reference field as shown above and include the invoice number shown in the table above.

Please note that assessments received after these dates will be subject to a $1,000.00 per day penalty in accordance with Section 5160-2-09 (L) of the Ohio Administrative Code. **If your HCAP assessments are late, they will delay the operation of the HCAP program.**

Payments to hospitals will be made in two installments. The first payment will be made on or about June 22, 2015 and the second will be made on or about July 8, 2015.

The following are data elements which are used in the 2014 HCAP Calculation.

2014 Hospital Care Assurance Program Data Summary for Provider «ProvNum»			
Data Element	**Value**	**Data Element**	**Value**
Adj. Total Facility Costs	«ATFC»	Total Title V Costs	«TVC»
Total Facility Days	«TFD»	Total MCaid I/P Costs	«TMIPC»
Total Medicaid Days	«TMD»	Total MCaid I/P Payments	«TMIPPay»
Total I/P MCaid HMO Days	«THMODay»	Total MCaid O/P Costs	«TMOPC»
UC Costs DA w/Ins	«UCDAw»	Total MCaid O/P Payments	«TMOPPay»
UC Costs <100 w/Ins	«UCb100w»	Total MCaid HMO I/P Costs	«TMCPIPC»
UC Costs DA w/o Ins	«UCDAwo»	Total MCaid HMO I/P Pmts	«TMCPIPPay»
UC Costs <100 w/o Ins	«Ucbwo»	Total MCaid HMO O/P Costs	«TMCPOPC»
UC Costs >100 w/o Ins	«Ucawo»	Total MCaid HMO O/P Pmts	«TMCPOPPay»

Note: Uncompensated Care (UC) data elements are combined inpatient and outpatient amounts

If you have questions, contact Jody Swisher at (614) 752-4258.

Sincerely,

Doug Henkel
Bureau of Health Plan Policy