

# Hospital Care Assurance Program (HCAP) FFY 2006 Program Year Testimony and Comments

Since the 2006 HCAP Forum was held as a video conference and the written testimony was not available at all locations, the following are the written testimony and comments provided by the 12/16/05 HCAP video conference forum attendees so that all concerned parties may have an opportunity to view this information.

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## [Summary of Comments & JFS Response](#)

Testimony from:

[The MetroHealth System](#)

[Ohio Children's Hospital Association](#)

[Berger Health System](#)

[Community partners for Affordable, Accessible Health Care](#)

## **ODJFS Response to Comments provided at the 2006 Hospital Care Assurance Program (HCAP) Forums**

The following is the Ohio Department of Job and Family Services' (ODJFS) response to the comments presented at the Federal Fiscal Year (FFY) 2006 Hospital Care Assurance Program (HCAP) video conference forum originating in Columbus on December 16, 2005 with participation from Toledo, Cleveland, and Cincinnati on that same date. ODJFS is holding these forums prior to developing the HCAP 2006 policy so that the comments may be considered prior to proposing any rules in March.

The following is a summary of comments received from forum attendees and ODJFS' response to those comments.

### **Comment regarding increasing DSH Limit for Public Hospitals**

Comment: (Requesting an increase to 155% DSH Limit.) At the current year's percent, 130%, the model continues to shortchange public hospitals for accessing supplemental funds from the Federal Government through the UPL program.

Comment: At minimum, the hospital requests that the limit be maintained at 130%, it should be noted that at 130% the HCAP model shorts public hospitals for accessing funds from the UPL program. Therefore, it is requested that ODJFS consider increasing the 130% adjustment to no less than 155%.

Response: In continued conversations between ODJFS staff, public hospital staff along with industry trade organization staff, we maintain that we will implement policy based on input from the hospital industry as a whole and input collected from all interested parties. Since an additional increase in the DSH limit would continue to impact all hospitals, we would not want to circumvent this process. This continues to be a challenging conversation due to increased statewide uncompensated care costs for hospitals that do not have other funding streams to support these increasing costs, along with federal DSH funding that will remain at the FFY 2004 level until FFY 2011. We look forward to working with the hospital industry on the policy for HCAP 2006, including discussions around the implementation of additional enhancements to the DSH limit for public hospitals. Note, that increases to the DSH limit are subject to approval from CMS.

### **Comments regarding the principle distribution of the HCAP funds**

Comment: Historically a guiding principle of the HCAP program is to assess and distribute the available funding through a formula that is fair and equitable and that the dollars should follow the patient.

Comment: Distribution of HCAP funds should be through a formula that is equitable, fair, stable, predictable, timely, and simple, with equity and fairness determined using a quantifiable measure, such as the degree to which the program equalizes the proportion of Medicaid losses and uncompensated care as a share of facility size (or costs).

Comment: The HCAP distribution formula should be prioritized and guided by the principles of (1) targeted toward the medically indigent and the most vulnerable patients, (2) maximized for use of the provision of uncompensated care, and (3) should follow the patients.

Response: ODJFS agrees that the guiding principles of the state disproportionate share program are that the money should follow the indigent patients and that the dollars are to help compensate hospitals for uncompensated care costs incurred while providing care to the indigent.

### **Comments regarding the Disproportionate Share Limit Pool**

Comment: The Disproportionate Share Limit Pool should be eliminated, it is the one HCAP pool that does not follow the patient.

Response: The Disproportionate Share Limit Pool provides a distribution of HCAP funds for uncompensated care reported by hospitals that have not received their maximum allowable amount of HCAP funds through other distribution pools. Like all the other pools in the HCAP formula, the Disproportionate Share Limit pool never provides funding to a hospital in excess of their disproportionate share limit – the amount of uncompensated costs the hospital incurred while caring for indigent patients. This pool is consistent with Federal requirements for distributing disproportionate share funds and takes into consideration the state-wide impact of the HCAP program and access to hospital services.

### **Comments regarding the HCAP requirements in Ohio Hospitals**

Comment: In the last two years, UHCAN Ohio has done surveys of hospitals in Cleveland and Columbus which found that hospitals were not posting HCAP signage requirements at the requisite locations, and hospitals have been inconsistently notifying patients eligible for HCAP of its availability.

Response: Annually, the Department completes a random audit of hospitals (25 in 2005) for adherence to OAC rules 5101:3-2-24 entitled “Audits” and 5101:3-2-07.17 entitled “Provision of Basic, Medically Necessary Hospital Level Services”. The findings from this audit are reported back to the individual hospital and a summary is available on the ODJFS website. During the HCAP 2005 Data Review process, the department for the first time required that hospitals submit photographic evidence of signs posted at hospitals in order to verify their existence, clarity and location as required by OAC 5101:3-2-07.17(D). We will continue to audit hospitals to ensure compliance with HCAP notification and eligibility policies.

## **Comments regarding the public input process for HCAP**

Comment: Multiple comments were made applauding ODJFS for giving individuals and groups across the state the opportunity to give input into the HCAP formula before it has been drafted.

Comment: We are appreciative that substantial notice to the communities was provided for this year's forums and look forward to similar advance notice in the future.

Response: We will continue to provide substantial notice to communities regarding HCAP policy forums. ODJFS posts notification of these forums on our web site at <http://jfs.ohio.gov/ohp/bhpp/hcap> and at local ODJFS offices. In addition to the public input ODJFS collects through the forums, ODJFS also takes input throughout the year by meeting with interested parties, through telephone conversations and other correspondence, and through the formal rule making process (e.g., clearance and public hearings). These communications are designed and implemented to allow all interested parties the opportunity to have their comments heard and included in the development of the program.



The MetroHealth System  
3300 MetroHealth Drive  
Cleveland, Ohio 44106-1908

316 778-7800

December 15, 2005

Ohio Department of Job and Family Services  
30 East Broad Street, 31st Floor  
Columbus, Ohio 43215

**RE: 2006 Hospital Care Assurance Program - Public Forum December 16, 2005**

Dear ODJFS:

The MetroHealth System (MHS) appreciates the opportunity to comment and share its views regarding the 2006 Hospital Care Assurance Program (HCAP). Being one of the state's largest Medicaid providers and also the largest provider of uncompensated care, MHS is heavily dependent on both the HCAP and supplemental Upper Payment Limit (UPL) funding dollars. The one key component of the HCAP program that also influences the UPL program is the Disproportionate Share (DSH) Payment Limit or OBRA Cap.

Federal law as enacted by the Benefits Improvement and Protection Act of 2000 (BIPA), permits States to increase the DSH payment limits by up to 175% for public hospitals for a two-year period. Discussions with the Ohio Department of Job and Family Services (ODJFS) over the last few years have defined those two years as 2005 and 2006.

In the 2005 HCAP program, the OHA Board recommended and the ODJFS included a 130% OBRA Cap for public hospitals, which CMS approved for 2005. We thank you for your support of this important plan amendment.

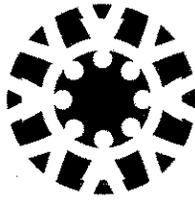
**The MetroHealth System requests that ODJFS again support the increase in the DSH limit for the 2006 HCAP program year as provided in federal legislation.** MHS requests that the limit be raised to 155%. At the prior year's percent, 130%, the model continues to shortchange public hospitals for accessing supplemental funds from the Federal Government through the UPL program. Public hospitals should not receive less HCAP funds due to the existence of a Medicaid State Plan Amendment that results in an understated OBRA Cap.

Historically a guiding principle of the HCAP program is to assess and **distribute the available HCAP funds through a formula that is fair and equitable and that the dollars should follow the patients.** The purpose of the program is to recognize and reimburse hospitals that serve a disproportionate share of Medicaid and indigent patients. MHS feels that the continued increase in the DSH limit for the public hospitals in 2006 would meet both principles.

Please feel free to contact me if you have any questions or if you need any additional information from MHS on this issue.

Sincerely,

Nancy Fisher Crum  
Vice President & Chief Financial Officer



## Ohio Children's Hospital Association

Progress is a healthy child

### Hospital Care Assurance Program (HCAP)

#### 2006 Public Forum

Ohio Department of Job and Family Services

December 16, 2005

Columbus, Ohio

### STATEMENT OF THE OHIO CHILDREN'S HOSPITAL ASSOCIATION

The Ohio Children's Hospital Association appreciates the opportunity to share the views of its members regarding the 2006 Hospital Care Assurance Program (HCAP). As major recipients of the funds distributed under this program, children's hospitals and the children they serve have an enormous stake in the program's viability, fairness, and effectiveness achieving its goals.

The most important purpose of the HCAP program should be to reimburse hospitals, such as children's hospitals, which serve a disproportionate share of Medicaid and low-income patients. Such reimbursement takes into account the extraordinary operating costs associated with serving a disproportionately high number of Medicaid and indigent patients.

The 2005 program made important progress in easing the average burden of Medicaid losses and uncompensated care borne by children's hospitals. That burden, as a share of facility costs, declined from over 5% to 4%, thanks in part to the creation of the children's hospital pool. Yet, the burden remains above the average for all hospitals, so we look forward to working with ODJFS to reduce this disparity further in 2006.

#### General Statement of Goals for HCAP

In the view of children's hospitals, the operating goals of the HCAP program as currently structured and funded (through hospital assessments and federal funds) should be to:

1. Capture all available federal Medicaid disproportionate share hospital dollars.
2. Fully reimburse disproportionate share hospitals for the costs of providing care to individuals who are covered by the Medicaid program (both fee-for-service and managed care) or are otherwise low-income, and then and only then attempt to reimburse hospitals for general uncompensated care costs.
3. Address the unique economic circumstances of true disproportionate share hospitals, as currently defined. Hospitals serving a disproportionate share of Medicaid and low-income patients, accounting for up to 50% of each hospital's book of business, must

establish a range of costly programs and services appropriate to and accommodating the special needs of the indigent. Even though many of these special services are put in place almost entirely for Medicaid and other indigent patients, only a portion of their cost can be reported directly on Medicaid cost reports.

Moreover, accommodating special needs entails a range of costs that are not only non-reportable but also difficult or impossible to quantify, such as the inefficiencies associated with high and widely variable appointment no-show rates.

Among disproportionate share hospitals, children's hospitals face another unique circumstance – they do not receive any federal Medicare disproportionate share funds that help adult hospitals manage uncompensated care and Medicaid losses.

4. Distribute HCAP funds through a formula that is equitable, fair, stable, predictable, timely, and simple, with equity and fairness determined using a quantifiable measure, such as the degree to which the program equalizes the proportion of Medicaid losses and uncompensated care as a share of facility size (or costs).

In an era of severe budget shortfalls, policymakers may be pressed to consider alternative uses and goals for the program, such as using it to finance broad-based health insurance coverage programs or to promote expansion of alternative health care service delivery models. Children's hospitals would strongly oppose such efforts in that they would in all likelihood reduce the resources that would be available to them to fulfill their missions.

### **Options for 2006**

Children's hospitals are now involved in a review of the program with their colleagues in the hospital community. A range of proposals for distributing the burden of Medicaid losses, uncompensated care, and hospital assessments is being considered. As this review continues, we are committed to the principles and goals outlined above and are working to maximize the degree to which the hospital community's recommendations reflect them.

As ODJFS continues its own review in preparation for filing a rule later this winter, children's hospitals hope it will join them in placing appropriate emphasis on the priorities that give the program its ultimate meaning – namely, ensuring that Ohio's safety net hospitals can continue providing exceptional service to all Ohioans who need hospital care, regardless of ability to pay.

We hope gains reducing the above-average burden borne by children's hospitals can be achieved through a higher allocation to the children's hospital pool, to the high DSH pool, and/or the Medicaid cost pool, on the understanding the allocations would be funded by a reduction in the assessment return pool.

Thank you for the opportunity to comment on this vital source of support for the work children's hospitals do to care for all patients, regardless of ability to pay or source of coverage.



# BERGER HEALTH SYSTEM

600 North Pickaway Street, Circleville, Ohio 43113 (740) 474-2126

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December 15, 2005

Ohio Department of Job and Family Services  
30 East Broad Street, 31st Floor  
Columbus, Ohio 43215

**RE: 2006 Hospital Care Assurance Program – Public Forum December 16, 2005**

Dear ODJFS:

Berger Hospital is utilizing this letter to share its comments on the 2006 Hospital Care Assurance Program (HCAF). Being Pickaway County's major Medicaid and uncompensated care provider, Berger relies on both HCAP and Upper Payment Limit (UPL) funding.

A key component of the HCAP program that influences the UPL program is the Disproportionate Share (DSH) Payment Limit or OBRA Cap. Federal law as enacted by the Benefits Improvement and Protection Act of 2000 (BIPA) permits States to increase the DSH payment limits by up to 175% for public hospitals for a two-year period. Discussions with the Ohio Department of Job and Family Services (ODJFS) over the last few years have defined those two years as 2005 and 2006.

In the 2005 HCAP program, the OHA Board recommended and the ODJFS included a 130% OBRA Cap increase for public hospitals. This increase was approved by CMS approved for 2005. Thank you for your support of this important plan amendment.

Berger Hospital requests that ODJFS again support the increase in the DSH limit for the 2006 HCAP program year. At a minimum, Berger Hospital requests that the limit be maintained at 130%. It should be noted that at 130% the HCAP model shorts public hospitals for accessing funds from the UPL program. Public hospitals should not receive less HCAP funds due to the existence of a Medicaid State Plan Amendment that results in an understated OBRA Cap. Therefore, we request that ODJFS consider increasing the 130% adjustment to no less than 155%.

Please feel free to contact me if you have any comments or questions.

Sincerely,



Tim A. Colburn  
Vice President Finance  
Berger Health System

**CPAAHC**

COMMUNITY PARTNERS for AFFORDABLE, ACCESSIBLE HEALTH CARE  
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**Statement by  
The Community Partners for Affordable Accessible Health Care Coalition  
HCAP Public Hearing  
December 16,2005  
Presented by Tim Walters**

My name is Tim Walters. I am here today representing the Community Partners for Affordable Accessible Health Care (CPAAHC). We are a diverse group of over 30 community groups and human service organizations working on issues relating to the provision of and access to health care to vulnerable people particularly in Cuyahoga County.

We would like to begin by again applauding ODJFS for giving individuals and groups across the state the opportunity to give input into the HCAP formula through today's regional forum prior to the formula before it has been drafted. We are appreciative that substantial notice to the communities was provided for this year's forums. We hope that we can expect similar advance notice for the public hearing(s) after the formula is prepared (unlike in 2004).

When examining how the HCAP distribution formula should be prioritized, CPAAHC continues to be guided by the following principles:

1. HCAP funds should be targeted toward the medically indigent and the most vulnerable patients.
2. HCAP funds should be maximized for use for the provision of uncompensated care.
3. HCAP funds should follow the patients.

Based on these principles, CPAAHC continues to believe that the Disproportionate Share Limit Pool should be eliminated. This pool allocates over \$74 million to all hospitals regardless of the amount of uncompensated care provided, to ensure that all hospitals receive a return of at least 50% of their HCAP assessment. It is rewarding hospitals (particularly large hospitals) that are providing minimal uncompensated care with HCAP funds. It is the one pool in the HCAP formula which HCAP funds clearly do not follow the patient. With the number of uninsured continuing to rise in Ohio, and the demands for HCAP funds increasing, the Disproportionate Share Limit Pool is not an allocation that can continued to be maintained. On the contrary, we believe that in its place there should be an additional allocation to Ohio's major safety net hospitals that are affording the heaviest amount of uncompensated care.

Another issue that we would like to raise is the implementation of the HCAP requirements by hospitals across Ohio. In the last two years UHCAN Ohio has done surveys of hospitals in Cleveland and Columbus which found that hospitals were not posting HCAP required signage requirements at the requisite locations, and hospitals have been inconsistently notifying patients eligible for HCAP of its availability. Negotiations are currently going on to rectify these problems in Cleveland and Columbus area hospitals. Nevertheless, it is probable that if these problems are occurring in Columbus and Cleveland, that they are occurring in hospitals across the state. We would request that ODJFS develop a program to monitor how HCAP is being communicated to patients across the state allowing for the proper enforcement from your office.

Finally, as ODJFS is working to prepare this year's HCAP formula and is looking to the future to maximize the HCAP Program, we are again requesting that you establish an advisory committee to develop the HCAP formula. The advisory committee should be

composed of representatives of Ohio Hospital Association (OHA), Health Policy Institute of Ohio and health care consumer and advocacy groups. You will probably note that we made the same request last year and there was no action forthcoming. We still feel very strongly about the need for such a committee and urge that ODJFS move forward on our request this year.

We again thank you for holding the regional hearing, and hope that you will implement our recommendations.

Community Partners for Affordable Accessible Health Care:

Citizens to Save Our MetroHealth, Council for Economic Opportunities of Greater Cleveland, El Barrio, Environmental Health Watch, Friendly Inn Settlement, Harvard Community Services Center, Immigrant Health Care Access Coalition, Jobs With Justice, League of Women Voters-Cuyahoga Regional Area, Lexington Bell Community Center, May Dugan Multi-Service Center, Merrick House, Merrick House West, Neighborhood Centers Association, Redeemer Crisis Center, St. Augustine's Hunger Center, St. Philip Neri's Project Hope, Stop Targeting Ohio's Poor, Tremont Neighborhood Opportunity Center, Tremont Community Health Board, Tremont Older Persons Program, UHCAN Ohio, Women Speak Out for Peace and Justice, Women for Racial and Economic Equality, Pilgrim Church, Organize! Ohio, Bridgeway, Neighborhood Family Practice, North Coast Health Ministry, Congregation of St. Joseph