HB11-1025

Colorado Legislative Council Staff Fiscal Note

FINAL FISCAL NOTE

Drafting Number:	LLS 11-0548	**Date:**	May 12, 2011
Prime Sponsor(s):	Rep. Joshi Sen. Lundberg	**Bill Status:**	Postponed Indefinitely
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TITLE: CONCERNING THE REPEAL OF PROVISIONS RELATED TO THE HOSPITAL PROVIDER FEE.

Fiscal Impact Summary	FY 2011-12	FY 2012-13	FY 2013-14
State Revenue			
Cash Funds			
Hospital Provider Fee Cash Fund	($436.2 million)	($523.4 million)	($628.1 million)
State Expenditures	**($1.05 billion)**	**($1.08 billion)**	**($1.13 billion)**
General Fund	101.5 million	59.5 million	15.8 million
Multiple Cash Funds	(625.8 million)	(595.0 million)	(653.0 million)
Federal Funds	(521.4 million)	(539.9 million)	(497.5 million)
FTE Position Change	(28.8) FTE	(29.5) FTE	(29.5) FTE

Effective Date: The bill was postponed indefinitely by the House Health and Environment Committee on February 22, 2011.

Appropriation Summary for FY 2011-2012: See State Appropriations section.

Local Government Impact: See Local Government Impact section.

Summary of Legislation

This bill repeals the Health Care Affordability Act of 2009 (House Bill 09-1293), which established the hospital provider fee. It requires the Department of Health Care Policy and Financing (DHCPF) to pay hospitals, except those operated by the Department of Human Services, for services based on the Medicare system. Eligibility for public health programs is reduced as follows:

- **Medicaid** -- parents of children who are eligible for Medicaid or the Children's Basic Health Plan (known as CHP+) will qualify for services based on family incomes of 60 percent or less of the federal poverty level (FPL). Under current law, this amount is up to 100 percent of the FPL.

- **CHP+** -- children under the age of 19 and pregnant women will qualify for services based on family incomes of 205 percent of the FPL, unless appropriations are available to extend eligibility to the current law level of 250 percent of the FPL.

Background

House Bill 09-1293. This bill authorized the DHCPF to collect hospital provider fees for the purpose of obtaining federal financial participation for the state's medical assistance programs. On March 31, 2010, the Centers for Medicare and Medicaid Services (CMS) approved the hospital provider fee and for payments to be retroactively effective July 1, 2009. Fees are set annually by the State Medical Services Board based on federal regulations. In FY 2009-10, the state retained $302.9 million in hospital provider fees. With federal matching funds, a total of $637.8 million in expenditures were made. The bill directs hospital provider fees to be used as follows:

- to **increase reimbursements to hospitals** through maximized provider payments, increased payments to safety-net providers under the Colorado Indigent Care Program (CICP) to 100 percent of cost, and by paying a new quality incentive payment. In FY 2009-10, $590.2 million was expended for supplemental Medicaid and CICP provider payments.

- for **expanding medical assistance programs**. Under the bill, eligibility for CHP+ was increased from 205 percent of the FPL to 250 percent. Children in Medicaid were provided 12 months of continuous eligibility, and the income eligibility limit for parents was increased from 60 percent of the FPL to 100 percent. The bill also created a new Medicaid buy-in program for disabled persons with incomes of up to 450 percent of the FPL, and allowed Medicaid to cover adults without dependent children with incomes of up to 100 percent of the FPL. In FY 2009-10, $3.3 million was used to expand coverage to 27,700 new clients, and $46.3 million was used to support Medicaid program costs.

- to **pay the administrative costs** related to the fee and program expansions. A total of $2.9 million was expended in FY 2009-10.

Federal health care law. The Patient Protection and Affordable Care Act (PPACA) sets forth new federal requirements that impact Medicaid beginning in 2014, and interact with the changes proposed under HB11-1025. Key provisions of PPACA:

- prohibit a state from reducing Medicaid eligibility levels below those in place when PPACA became law on March 23, 2010;
- expand Medicaid to serve persons with incomes of up to 133 percent of the FPL;
- require states to reimburse Medicaid providers 100 percent of Medicare rates for federal fiscal years 2012-13 and 2013-14; and
- gradually reduce federal moneys available for Disproportionate Share Hospital (DSH) payments, which are used to offset hospitals' costs for providing uncompensated care.

State Revenue

This bill is expected to reduce state cash fund revenue by $436.2 million in FY 2011-12, $523.4 million in FY 2012-13, and $628.1 million in FY 2013-14. While the hospital provider fee is expected to increase at annual rates of between 16 and 29 percent during its phase-in period between FY 2010-11 and FY 2013-14, the fiscal note assumes an annual increase of 20 percent from the $302.9 million collected in FY 2009-10. These moneys are eligible for a federal match, which reduces the amount of federal funds available to the state by an equal amount.

State Expenditures

This bill will reduce state expenditures state expenditure in the DHCPF by $1.05 billion and 28.8 FTE in FY 2011-12; $1.08 billion and 29.5 FTE in FY 2012-13; and $1.13 billion and 29.5 FTE in FY 2013-14. **However, while the bill reduces cash and federally funded expenditures, it increases General Fund expenditures by at least $101.6 million in FY 2011-12**, $59.5 million in FY 2012-13, and $15.8 million in FY 2013-14. Table 1 and the discussion that follows address the cost reductions under the bill.

Table 1. Reduction in Expenditures Under HB11-1025

Cost Components	FY 2011-12	FY 2012-13	FY 2013-14
Personal services	($1,870,439)	($2,137,644)	($2,137,644)
FTE	(28.8)	(29.5)	(29.5)
Operating costs	(308,810)	(244,828)	(245,498)
Professional services and contractors	(6,087,372)	(6,335,409)	(6,535,630)
Client outreach	(112,218)	(142,665)	(43,991)
Medicaid program	(732,892,221)	(1,006,706,141)	(1,044,766,983)
Safety-net provider payments	(263,707,578)	6,299,488	6,299,488
CHP+ program	(37,072,218)	(58,394,631)	(77,621,201)
Information technology costs	(3,701,064)	(7,736,063)	(9,680,256)
TOTAL	**($1,045,751,920)**	**($1,075,397,893)**	**($1,134,741,715)**
General Fund	**101,506,788**	**59,485,383**	**15,766,773**
Cash Funds	**(625,825,040)**	**(594,987,359)**	**(652,991,972)**
Federal Funds	**(521,433,667)**	**(539,895,917)**	**(497,516,516)**

Expenditure reductions under the bill. Overall, reductions in state expenditures increase over time by eliminating costs that would have otherwise grown as caseload expanded to serve new clients. The fiscal note assumes that all functions related to the hospital provider fee are eliminated, but that some functions paid for with its revenue are retained to meet federal requirements.

Personal services - ($1.9 million) in FY 2011-12. Within the DHCPF, there are currently 52 FTE funded with moneys from the Hospital Provider Fee Cash Fund and federal funds. Staff provide a range of functions for the Medicaid and CHP+ programs, including determining eligibility, coordinating service delivery, processing claims, quality assurance, and contract management. The fiscal note assumes that a total of 29.5 FTE (prorated to 28.8 FTE in FY 2011-12) would be reduced, saving an estimated $2.1 million per year. The remaining 22.5 FTE are needed to comply with multiple federal law requirements, including the implementation of PPACA. By eliminating the hospital provider fee, General Fund moneys are required to backfill the state's share of these costs.

Operating costs - ($309,000) in FY 2011-12. Operating costs will be reduced by eliminating staff and the 13-member advisory board created to oversee the hospital provider fee. In FY 2011-12, administrative costs of $125,822 and leased space costs of $183,000 are reduced.

Professional services and contractors - ($6.1 million)in FY 2011-12. Contracts with vendors to assist in program administration are reduced under the bill, including contracts to administer the hospital provider fee; provide eligibility, benefit design and quality and utilization reviews for programs; provide enrollment assistance to clients in hospitals; legal services; and conduct actuarial assessments. These reductions are partially offset by an increase in contracting costs to re-price medical provider reimbursement rates to align with the methodology required by the bill and for auditing needed to take into account the repeal of hospital provider fee.

Client outreach - ($112,000) in FY 2011-12. With eligibility reductions in place, costs to conduct outreach to newly eligible groups are reduced.

Medicaid program - ($732.9 million) in FY 2011-12. The bill lowers Medicaid eligibility for parents from 100 percent of the FPL to 60 percent. It also eliminates planned expansions of coverage to include adults without dependent children and the Medicaid buy-in program for disabled non-working adults and children, scheduled for implementation within the next year. As a result, Medicaid caseload and associated costs are reduced each year.

However, under current law, the DHCPF is required to provide Medicaid services to individuals who lose their eligibility as a result of increased earnings or hours of employment, which could extend services for affected clients through June 30, 2012. With the elimination of the hospital provider fee, these costs will be paid with General Fund moneys. For FY 2011-12, the bill reduces county administration costs by $2.4 million, medical services premiums by $586.7 million, and mental health payments by $19 million. These costs were expected to increase each year, based on a projected caseload growth of 3 percent per year, but do not include the anticipated increases under PPACA.

Safety-net provider payments - ($263.7 million, one-time reduction)in FY 2011-12. With the repeal of HB09-1293, less moneys are available to make payments to safety-net providers that participate in the CICP. These payments were increased to 75 percent of costs in FY 2010-11, up from 50 percent. Payments were anticipated to rise to 100 percent over time under HB09-1293. The fiscal note assumes reimbursements will be reduced to 50 percent beginning in FY 2011-12, resulting in a one-year savings of $263.7 million. However, the fiscal note assumes that General Fund moneys will be required to meet the 50 percent of cost reimbursement rate, which increases costs by $6.3 million per year, beginning in FY 2012-13.

CHP+ program - ($37.1 million) in FY 2011-12. HB11-1025 lowers eligibility from 250 percent of the FPL to 205 percent, unless General Fund moneys are available to make up the difference. This will reduce CHP+ caseload and associated costs each year. However, under current law, children eligible for CHP+ are guaranteed eligibility for 12 months. The fiscal note assumes that children could access services up to June 30, 2012. With the elimination of the hospital provider fee, these costs would be paid with General Fund moneys. For FY 2011-12, the bill reduces CHP+ administrative costs by $25,000, medical premiums by $35 million, and dental costs by $2.1 million. These costs were anticipated to increase each year, based on projected caseload growth of 2.43 percent per year.

Information Technology Costs - ($3.7 million) in FY 2011-2. One-time costs will be needed to modify the Colorado Benefits Management System (CBMS) and Medicaid Management Information System (MMIS) to reflect the new eligibility criteria. In addition, the fiscal note assumes that the federal share of recent systems changes to expand services under HB09-1293 will require reimbursement using General Fund moneys. Ongoing costs will be incurred to update these systems annually as new provider reimbursement rates are established, however the planned system upgrades to expand eligibility called for under HB09-1293 are eliminated.

Legislative branch, costs not included. The fiscal note assumes that the State Auditor will still be required to audit the program as required under HB09-1293, but that legislative services agencies will not be required to conduct a post-enactment review of the hospital provider fee.

Federal Health Care Law. As discussed in the background section above, federal health care laws create impacts to medical assistance programs over the next several fiscal years and interact with provisions of HB11-1025.

Impacts of reducing caseload for medical assistance programs under HB11-1025. Colorado can reduce the Medicaid and CHP+ expansions made under HB09-1293 without violating PPACA through December 31, 2013. Beginning on January 1, 2014, persons with incomes of up to 133 percent of the FPL become eligible for Medicaid under federal law. Enhanced federal moneys are available to meet the gap between a presumed threshold of 100 percent of the FPL and the new rate of 133 percent. If Medicaid eligibility is below 100 percent of the FPL when PPACA takes effect, Colorado will be required to increase its half of costs accordingly. In the current fiscal year 2010-11, the state's share of Medicaid expenditures are paid with General Fund augmented with cash funds, including tobacco taxes and hospital provider fees.

Increasing Medicaid costs under PPACA. In addition to the costs resulting from caseload expansion under PPACA, the state will be required to pay enhanced rates for Medicaid providers in federal fiscal years 2012-13 and 2013-14. This amount is anticipated to be at least $2.4 million per year from the General Fund, unless cash funds are available.

Hospital reimbursement under PPACA. Because it assumes that more people will have some sort of health care coverage and hospitals will therefore experience less uncompensated care, the federal share for DSH payments is reduced beginning in 2014. If less people are eligible for and enrolled in medical assistance programs and do not have private health insurance, uncompensated care will increase. With reduced federal funding and the elimination of hospital provider fee

revenue, House Bill 11-1025 is anticipated to have a significant fiscal impact on both public and private hospitals. Assuming DSH payments are phased out entirely, payments to hospitals could be reduced by at least $539 million per year, on top of the lowered rates for reimbursement of costs.

Local Government Impact

This bill will reduce the number of clients served in public health programs. As certain administrative functions of Medicaid are managed at the county level, this bill will reduce county administration payments by $2.4 million in FY 2011-12, and $2.6 million each year thereafter.

State Appropriations

For FY 2011-12, the Department of Health Care Policy and Financing requires a reduction in appropriations by $1.05 billion and 28.8 FTE, including a reduction of $625.8 million cash funds from multiple sources, and $521.4 million federal funds, and an increase of $101.5 million General Fund.

Departments Contacted

Health Care Policy and Financing	Higher Education	Human Services
Joint Budget Committee	Law	Legislative Council
Office of Information Technology	State Auditor	Treasury