First Regular Session
Seventieth General Assembly
STATE OF COLORADO

ENGROSSED
This Version Includes All Amendments Adopted
on Second Reading in the House of Introduction

LLS NO. 15-0307.03 Jason Gelender x4330 **HOUSE BILL 15-1389**

HOUSE SPONSORSHIP

Hullinghorst and Court,

SENATE SPONSORSHIP

Steadman,

House Committees
Health, Insurance, & Environment
Appropriations

Senate Committees

A BILL FOR AN ACT

CONCERNING THE CREATION OF AN ENTERPRISE THAT IS EXEMPT FROM THE REQUIREMENTS OF SECTION 20 OF ARTICLE X OF THE STATE CONSTITUTION TO ADMINISTER A STATE HOSPITAL PROVIDER FEE PROGRAM.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://www.leg.state.co.us/billsummaries.)

The bill creates the health care affordability enterprise (enterprise) as a **type 2** agency and government-owned business within the department of health care policy and financing (HCPF) for the purpose

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.
Capital letters indicate new material to be added to existing statute.
Dashes through the words indicate deletions from existing statute.

HOUSE
2nd Reading Unamended
May 1, 2015

of charging and collecting a new hospital provider fee that replaces the existing hospital provider fee and participating in the implementation and administration of the state hospital provider fee program (program) created by the "Health Care Affordability Act of 2009" on and after July 1, 2016. The bill does not take effect if the federal centers for medicare and medicaid services determine that it does not comply with federal law. The enterprise is designated as an enterprise for purposes of the taxpayer's bill of rights (TABOR) so long as it meets TABOR requirements. The primary powers and duties of the enterprise are to:

- Charge and collect a new hospital provider fee;
- Leverage new hospital provider fee revenue collected to obtain federal matching money, working with or through HCPF and the state medical services board to the extent required by federal law or otherwise necessary; and
- Expend money from a newly created new hospital provider fee cash fund for the purposes of the program;
- Issue revenue bonds payable from its revenues;
- Enter into agreements with HCPF as necessary to collect and expend new hospital provider fee revenue;
- Engage the services of private consultants and legal counsel; and
- Adopt and amend or repeal policies for the regulation of its affairs and the conduct of its business.

The powers, duties, and functions of the existing hospital provider fee oversight and advisory board (advisory board) are transferred, by a **type 3** transfer, to the enterprise on July 1, 2016, and the advisory board is abolished. The current members of the advisory board continue to serve as members of the enterprise board, and future enterprise board appointments are done in the same way as current advisory board appointments.

The bill specifies that unlike hospital provider fees charged and collected by HCPF before July 1, 2016, so long as the enterprise qualifies as a TABOR-exempt enterprise, new hospital provider fee revenue does not count against either the TABOR state fiscal year spending limit or the referendum C cap, the higher statutory state fiscal year spending limit established after the voters of the state approved referendum C in 2005. The bill clarifies that termination of the authority of HCPF to charge and collect hospital provider fees and creation of a new enterprise to charge and collect a new hospital provider fee does not constitute qualification of an enterprise for purposes of TABOR or state law and therefore does not require or authorize downward adjustment of the TABOR fiscal year spending limit or the referendum C cap.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, 25.5-4-402.3, **amend** (2) (b), (2) (c) introductory portion, (3) (a) introductory portion, (3) (a) (III), (3) (b), (3) (c) (I) introductory portion, (3) (c) (II) introductory portion, (3) (c) (II) (C), (3) (c) (III) introductory portion, (3) (c) (III) (E), (3) (c) (III) (F), (3) (d), (3) (e), (3) (f), (3) (g), (4) (a), (4) (b) introductory portion, (4) (b) (IV) introductory portion, (4) (b) (VI), (5) (a) (I), (5) (b) introductory portion, (5) (b) (II), (5) (b) (III) (A), (5) (b) (III) (B), (5) (c), (6) (b) (I) introductory portion, (6) (b) (II), (6) (b) (III), (6) (b) (IV), (6) (c), (6) (d), (6) (e) introductory portion, (6) (e) (I), (6) (e) (II), (6) (e) (III), (6) (e) (VIII), (6) (e) (IX), (6) (f) introductory portion, (6) (f) (II), (6) (f) (III) introductory portion, and (6) (f) (IV); **repeal** (3) (a) (IV), (6) (a), and (6) (g); and **add** (2) (d), (2) (e), (2) (f), (2.5), (3) (c) (IV), (6) (b) (I.5), (6) (e) (VIII.5), and (6) (h) as follows:

25.5-4-402.3. Hospital providers - provider fees and new provider fees - legislative declaration - health care affordability enterprise - federal waiver - fund created - rules. (2) **Legislative declaration.** The general assembly hereby finds and declares that:

(b) Hospital providers within the state incur significant costs by providing uncompensated emergency department care and other uncompensated medical services to low-income and uninsured populations; ~~and~~

(c) This section is enacted as part of a comprehensive health care reform and is intended to provide the following ~~state~~ services and benefits TO HOSPITAL PROVIDERS AND INDIVIDUALS:

(d) (I) THE STATE DEPARTMENT CURRENTLY PROVIDES A BUSINESS SERVICE TO HOSPITALS WHEN, IN EXCHANGE FOR PAYMENT OF HOSPITAL PROVIDER FEES, IT OBTAINS FEDERAL MATCHING MONEY AND, AFTER

COVERING ITS ADMINISTRATIVE COSTS, RETURNS BOTH THE HOSPITAL PROVIDER FEES AND THE FEDERAL MATCHING MONEY TO HOSPITALS:

(A) DIRECTLY BY INCREASING REIMBURSEMENT RATES TO HOSPITALS FOR PROVIDING MEDICAL CARE UNDER THE STATE MEDICAL ASSISTANCE PROGRAM AND THE COLORADO INDIGENT CARE PROGRAM; AND

(B) INDIRECTLY BY INCREASING THE NUMBER OF INDIVIDUALS COVERED BY PUBLIC MEDICAL ASSISTANCE;

(II) IT IS NECESSARY, APPROPRIATE, AND IN THE BEST INTEREST OF THE STATE TO ACKNOWLEDGE THE NATURE OF THE BUSINESS SERVICE THAT THE STATE DEPARTMENT PROVIDES TO HOSPITALS BY CREATING A HEALTH CARE AFFORDABILITY ENTERPRISE AS A GOVERNMENT-OWNED BUSINESS WITHIN THE STATE DEPARTMENT AUTHORIZED TO CHARGE AND COLLECT A NEW HOSPITAL PROVIDER FEE AND BY DESIGNATING THE HEALTH CARE AFFORDABILITY ENTERPRISE AS AN ENTERPRISE FOR PURPOSES OF SECTION 20 OF ARTICLE X OF THE STATE CONSTITUTION SO LONG AS IT MEETS THE REQUIREMENTS OF THAT SECTION; AND

(III) CONSISTENT WITH THE DETERMINATION OF THE COLORADO SUPREME COURT IN *NICHOLL V. E-470 PUBLIC HIGHWAY AUTHORITY*, 896 P.2d 859 (COLO. 1995), THAT THE POWER TO IMPOSE TAXES IS INCONSISTENT WITH ENTERPRISE STATUS UNDER SECTION 20 OF ARTICLE X OF THE STATE CONSTITUTION, IT IS THE CONCLUSION OF THE GENERAL ASSEMBLY THAT THE NEW HOSPITAL PROVIDER FEE CHARGED AND COLLECTED BY THE HEALTH CARE AFFORDABILITY ENTERPRISE IS A FEE, NOT A TAX, BECAUSE IT IS IMPOSED FOR THE SPECIFIC PURPOSES OF ALLOWING THE ENTERPRISE TO DEFRAY ITS COSTS IN IMPLEMENTING AND ADMINISTERING THIS SECTION, OBTAIN FEDERAL MATCHING MONEY, AND

PROVIDE A SERVICE TO HOSPITALS BY INCREASING THE NET TOTAL AMOUNT OF REIMBURSEMENT PAID FOR THE MEDICAL CARE THAT THEY PROVIDE TO STATE-SUBSIDIZED PATIENTS;

(e) UNLIKE THE HOSPITAL PROVIDER FEE CHARGED AND COLLECTED BY THE STATE DEPARTMENT BEFORE JULY 1, 2016, SO LONG AS THE HEALTH CARE AFFORDABILITY ENTERPRISE QUALIFIES AS AN ENTERPRISE FOR PURPOSES OF SECTION 20 OF ARTICLE X OF THE STATE CONSTITUTION, THE REVENUES FROM THE NEW HOSPITAL PROVIDER FEE CHARGED AND COLLECTED BY THE ENTERPRISE ARE NOT STATE FISCAL YEAR SPENDING, AS DEFINED IN SECTION 24-77-102 (17), C.R.S., OR STATE REVENUES, AS DEFINED IN SECTION 24-77-103.6 (6) (c), C.R.S., AND DO NOT COUNT AGAINST EITHER THE STATE FISCAL YEAR SPENDING LIMIT IMPOSED BY SECTION 20 OF ARTICLE X OF THE STATE CONSTITUTION OR THE EXCESS STATE REVENUES CAP, AS DEFINED IN SECTION 24-77-103.6 (6) (b) (I) (B), C.R.S.; AND

(f) TERMINATION OF THE AUTHORITY OF THE STATE DEPARTMENT TO CHARGE AND COLLECT THE HOSPITAL PROVIDER FEE AND CREATION OF A NEW ENTERPRISE TO CHARGE AND COLLECT THE NEW HOSPITAL PROVIDER FEE DOES NOT CONSTITUTE QUALIFICATION OF AN ENTERPRISE FOR PURPOSES OF SECTION 20 OF ARTICLE X OF THE STATE CONSTITUTION OR SECTION 24-77-103.6 (6) (b) (II), C.R.S., AND DOES NOT REQUIRE OR AUTHORIZE ADJUSTMENT OF THE STATE FISCAL YEAR SPENDING LIMIT CALCULATED PURSUANT TO SECTION 20 OF ARTICLE X OF THE STATE CONSTITUTION OR THE EXCESS STATE REVENUES CAP, AS DEFINED IN SECTION 24-77-103.6 (6) (b) (I) (B), C.R.S.

(2.5) (a) THE HEALTH CARE AFFORDABILITY ENTERPRISE, HEREINAFTER REFERRED TO IN THIS SECTION AS THE "ENTERPRISE", IS

HEREBY CREATED. THE ENTERPRISE IS AND OPERATES AS A GOVERNMENT-OWNED BUSINESS WITHIN THE STATE DEPARTMENT FOR THE PURPOSE OF CHARGING AND COLLECTING A NEW HOSPITAL PROVIDER FEE ON AND AFTER JULY 1, 2016, LEVERAGING NEW HOSPITAL PROVIDER FEE REVENUE TO OBTAIN FEDERAL MATCHING MONEY, AND EXPENDING THE FEE REVENUE AND MATCHING MONEY AS AUTHORIZED IN THIS SECTION.

(b) THE ENTERPRISE CONSTITUTES AN ENTERPRISE FOR PURPOSES OF SECTION 20 OF ARTICLE X OF THE STATE CONSTITUTION SO LONG AS IT RETAINS THE AUTHORITY TO ISSUE REVENUE BONDS AND RECEIVES LESS THAN TEN PERCENT OF ITS TOTAL REVENUES IN GRANTS FROM ALL COLORADO STATE AND LOCAL GOVERNMENTS COMBINED. SO LONG AS IT CONSTITUTES AN ENTERPRISE PURSUANT TO THIS PARAGRAPH (b), THE ENTERPRISE IS NOT SUBJECT TO ANY PROVISIONS OF SECTION 20 OF ARTICLE X OF THE STATE CONSTITUTION.

(c) THE ENTERPRISE'S PRIMARY POWERS AND DUTIES ARE:

(I) TO CHARGE AND COLLECT A NEW HOSPITAL PROVIDER FEE AS SPECIFIED IN SUBSECTION (3) OF THIS SECTION;

(II) TO LEVERAGE NEW HOSPITAL PROVIDER FEE REVENUE COLLECTED TO OBTAIN FEDERAL MATCHING MONEY, WORKING WITH OR THROUGH THE STATE DEPARTMENT AND THE STATE BOARD TO THE EXTENT REQUIRED BY FEDERAL LAW OR OTHERWISE NECESSARY; AND

(III) TO EXPEND NEW HOSPITAL PROVIDER FEE REVENUE, MATCHING FEDERAL MONEY, AND ANY OTHER MONEY FROM THE NEW HOSPITAL PROVIDER FEE CASH FUND AS SPECIFIED IN SUBSECTIONS (3) AND (4) OF THIS SECTION;

(IV) TO ISSUE REVENUE BONDS PAYABLE FROM THE REVENUES OF THE ENTERPRISE;

(V) TO ENTER INTO AGREEMENTS WITH THE STATE DEPARTMENT TO THE EXTENT NECESSARY TO COLLECT AND EXPEND NEW HOSPITAL PROVIDER FEE REVENUE;

(VI) TO ENGAGE THE SERVICES OF PRIVATE CONSULTANTS AND LEGAL COUNSEL FOR PROFESSIONAL AND TECHNICAL ASSISTANCE, ADVICE, AND OTHER SERVICES IN CONDUCTING ITS AFFAIRS WITHOUT REGARD TO THE PROVISIONS OF THE "PROCUREMENT CODE", ARTICLES 101 TO 112 OF TITLE 24, C.R.S.; AND

(VII) TO ADOPT AND AMEND OR REPEAL POLICIES FOR THE REGULATION OF ITS AFFAIRS AND THE CONDUCT OF ITS BUSINESS CONSISTENT WITH THE PROVISIONS OF THIS SECTION.

(d) THE ENTERPRISE SHALL EXERCISE ITS POWERS AND PERFORM ITS DUTIES AS IF THE SAME WERE TRANSFERRED TO THE STATE DEPARTMENT BY A **TYPE 2** TRANSFER, AS DEFINED IN SECTION 24-1-105, C.R.S.

(3) **Hospital provider fee and new hospital provider fee.** (a) Beginning with the fiscal year commencing July 1, 2009, and each fiscal year thereafter ENDING WITH THE FISCAL YEAR COMMENCING JULY 1, 2015, the state department is authorized to charge and collect hospital provider fees, as described in 42 CFR 433.68 (b), on outpatient and inpatient services provided by all licensed or certified hospitals, referred to in this section as "hospitals", for the purpose of obtaining federal financial participation under the state medical assistance program as described in this article and articles 5 and 6 of this title, referred to in this section as the "state medical assistance program", and the Colorado indigent care program described in part 1 of article 3 of this title, referred to in this section as the "Colorado indigent care program". FOR THE

FISCAL YEAR COMMENCING JULY 1, 2016, AND FOR EACH FISCAL YEAR THEREAFTER, THE ENTERPRISE IS AUTHORIZED TO CHARGE AND COLLECT A NEW HOSPITAL PROVIDER FEE, AS DESCRIBED IN 42 CFR 433.68 (b), ON OUTPATIENT AND INPATIENT SERVICES PROVIDED BY HOSPITALS FOR THE SAME PURPOSE. The hospital provider fees shall be used BY THE STATE DEPARTMENT BEFORE JULY 1, 2016, AND AFTER JULY 1, 2016, TO THE EXTENT NECESSARY TO EXPEND ALL HOSPITAL PROVIDER FEE REVENUE COLLECTED BEFORE JULY 1, 2016, AND THE NEW HOSPITAL PROVIDER FEE SHALL BE USED BY THE ENTERPRISE ON AND AFTER JULY 1, 2016, to:

(III) Pay the administrative costs, FROM HOSPITAL PROVIDER FEE REVENUE COLLECTED BEFORE JULY 1, 2016, ONLY, to the state department OR PAY THE ADMINISTRATIVE COSTS, FROM NEW HOSPITAL PROVIDER FEE REVENUE ONLY, TO THE ENTERPRISE in implementing and administering this section. ~~and~~

(IV) ~~Offset general fund expenditures for the state medicaid program for state fiscal years 2011-12 and 2012-13 only.~~

(b) The ENTERPRISE SHALL RECOMMEND FOR APPROVAL AND ESTABLISHMENT BY THE STATE BOARD THE AMOUNT OF THE NEW provider ~~fees shall be assessed pursuant to rules adopted by the state board, pursuant to section 24-4-103, C.R.S.~~ FEE THAT IT INTENDS TO CHARGE AND COLLECT. The STATE BOARD MUST ESTABLISH THE FINAL amount of the ~~fee shall be established by rule of the state board but~~ NEW PROVIDER FEE BY RULES PROMULGATED IN ACCORDANCE WITH ARTICLE 4 OF TITLE 24, C.R.S. THE STATE BOARD shall not ~~exceed~~ ESTABLISH ANY AMOUNT THAT EXCEEDS the federal limit for such fees. THE STATE BOARD MAY DEVIATE FROM THE RECOMMENDATIONS OF THE ENTERPRISE, BUT SHALL EXPRESS IN WRITING THE REASONS FOR ANY DEVIATIONS. In establishing

the amount of the fee and in promulgating the rules governing the fee, the state board shall:

(I) Consider recommendations of the ~~hospital provider fee oversight and advisory board established pursuant to subsection (6) of this section~~ ENTERPRISE; AND

(II) Establish the amount of the NEW provider fee so that the amount collected from the fee and federal matching funds associated with the fee are sufficient to pay for the items described in paragraph (a) of this subsection (3), but nothing in this subparagraph (II) shall require the state board to increase the NEW provider fee above the amount recommended by the ~~advisory board; and~~ ENTERPRISE.

(III) ~~Establish the amount of the provider fee so that the amount collected from the fee is approximately equal to or less than the amount of the appropriation specified for the fee in the general appropriation act or any supplemental appropriation act.~~

(c) (I) In accordance with the redistributive method set forth in 42 CFR 433.68 (e) (1) and (e) (2), the ENTERPRISE, ACTING IN CONCERT WITH OR THROUGH AN AGREEMENT WITH THE state department IF REQUIRED BY FEDERAL LAW, may seek a waiver from the broad-based NEW provider fees requirement or the uniform NEW provider fees requirement, or both. Subject to federal approval and to minimize the financial impact on certain hospitals, the ~~state department in consultation with the advisory board,~~ ENTERPRISE may exempt from payment of the NEW provider fee certain types of hospitals, including but not limited to:

(II) In determining whether a hospital may be excluded, the ~~state department~~ ENTERPRISE shall use one or more of the following criteria:

(C) A hospital whose inclusion or exclusion would not

significantly affect the net benefit to hospitals paying the NEW provider fee; or

(III) The ~~state department~~ ENTERPRISE may reduce the amount of the NEW provider fee for certain hospitals to obtain federal approval and to minimize the financial impact on certain hospitals. In determining for which hospitals the ~~state department~~ ENTERPRISE may reduce the amount of the NEW provider fee, the ~~state department~~ ENTERPRISE shall use one or more of the following criteria:

(E) If the hospital paid a reduced NEW provider fee, the reduced provider fee would not significantly affect the net benefit to hospitals paying the NEW provider fee; or

(F) The hospital is required not to pay a reduced NEW provider fee as a condition of federal approval.

(IV) THE ENTERPRISE MAY CHANGE HOW IT PAYS HOSPITAL REIMBURSEMENT OR QUALITY INCENTIVE PAYMENTS, OR BOTH, IN WHOLE OR IN PART, UNDER THE AUTHORITY OF A FEDERAL WAIVER IF THE TOTAL REIMBURSEMENT TO HOSPITALS IS EQUAL TO OR ABOVE THE FEDERAL UPPER PAYMENT LIMIT CALCULATION UNDER THE WAIVER.

(d) The ~~state department~~ ENTERPRISE may ~~with the approval of the advisory board,~~ alter the process prescribed in this subsection (3) to the extent necessary to meet the federal requirements and to obtain federal approval.

(e) (I) The ~~state board, in consultation with the advisory board~~ ENTERPRISE shall ~~promulgate rules~~ ESTABLISH POLICIES on the calculation, assessment, and timing of the NEW provider fee. The ~~state department~~ ENTERPRISE shall assess the NEW provider fee on a schedule to be set by the ~~state~~ ENTERPRISE board ~~through rule~~ AS PROVIDED IN PARAGRAPH (e)

OF SUBSECTION (6) OF THIS SECTION. The ~~state board rules shall require that the~~ periodic NEW provider fee payments from a hospital and the ~~state department's~~ ENTERPRISE'S reimbursement to the hospital under subparagraphs (I) and (II) of paragraph (b) of subsection (4) of this section are due as nearly simultaneously as feasible; except that the ~~state department's~~ ENTERPRISE'S reimbursement to the hospital shall be due no more than two days after the periodic NEW provider fee payment is received from the hospital. The NEW provider fee shall be imposed on each hospital even if more than one hospital is owned by the same entity. The fee shall be prorated and adjusted for the expected volume of service for any year in which a hospital opens or closes.

(II) The ~~state department~~ ENTERPRISE is authorized to refund any unused portion of the NEW provider fee. For any portion of the NEW provider fee that has been collected by the ~~state department~~ ENTERPRISE but for which the ~~state department~~ ENTERPRISE has not received federal matching funds, the ~~state department~~ ENTERPRISE shall refund back to the hospital that paid the fee the amount of such portion of the fee within five business days after the fee is collected.

(III) The ~~state board, in consultation with the advisory board shall promulgate rules on~~ ENTERPRISE SHALL ESTABLISH REQUIREMENTS FOR the reports that hospitals ~~shall be required to~~ MUST submit ~~for~~ TO the ~~state department~~ ENTERPRISE TO ALLOW THE ENTERPRISE to calculate the amount of the NEW provider fee. Notwithstanding the provisions of part 2 of article 72 of title 24, C.R.S., OR PARAGRAPH (h) OF SUBSECTION (6) OF THIS SECTION, information provided to the ~~state department~~ ENTERPRISE pursuant to this section ~~shall be considered~~ IS confidential and ~~shall not be deemed~~ IS NOT a public record. Nonetheless, the ~~state~~

~~department in consultation with the advisory board,~~ ENTERPRISE may prepare and release summaries of the reports to the public.

(f) A hospital shall not include any amount of the NEW provider fee as a separate line item in its billing statements.

(g) The state board shall promulgate any rules pursuant to the "State Administrative Procedure Act", article 4 of title 24, C.R.S., necessary for the administration and implementation of this section. Prior to submitting any proposed rules concerning the administration or implementation of the NEW provider fee to the state board, the state ~~department~~ BOARD shall consult with the ~~advisory board~~ ENTERPRISE on the proposed rules as specified in paragraph (e) of subsection (6) of this section.

(4) **Hospital provider fee and new hospital provider fee cash funds.** (a) All provider fees collected pursuant to this section BEFORE JULY 1, 2016, by the state department shall be transmitted to the state treasurer, who shall credit the same to the hospital provider fee cash fund FOR USE AS SPECIFIED IN THIS SECTION AS IT EXISTED PRIOR TO JULY 1, 2016. ALL NEW PROVIDER FEE REVENUE COLLECTED PURSUANT TO THIS SECTION ON AND AFTER JULY 1, 2016, BY THE ENTERPRISE SHALL BE TRANSMITTED TO THE STATE TREASURER, WHO SHALL CREDIT THE SAME TO THE NEW HOSPITAL PROVIDER FEE FUND, which fund is hereby created and referred to in this section as the "fund".

(b) All moneys in the fund ~~shall be~~ ARE subject to federal matching as authorized under federal law and ~~subject to annual appropriation by the general assembly~~ ARE CONTINUOUSLY APPROPRIATED TO THE ENTERPRISE for the following purposes:

(IV) Subject to available revenue from the NEW provider fee and

federal matching funds, to expand eligibility for public medical assistance by:

(VI) To pay the ~~state department's~~ ENTERPRISE'S actual administrative costs of implementing and administering this section, including but not limited to the following costs:

(A) ADMINISTRATIVE expenses of the ~~advisory board, including but not limited to the state department's personal services and operating costs related to the administration of the advisory board~~ ENTERPRISE;

(B) The ~~state department's~~ ENTERPRISE'S actual costs related to implementing and maintaining the NEW provider fee, including personal services, operating, and consulting expenses;

(C) The ~~state department's~~ ENTERPRISE'S actual costs for the changes and updates to the medicaid management information system for the implementation of subparagraphs (I) to (III) of this paragraph (b);

(D) The ~~state department's~~ ENTERPRISE'S personal services and operating costs related to personnel, consulting services, and for review of hospital costs necessary to implement and administer the increases in inpatient and outpatient hospital payments made pursuant to subparagraph (I) of this paragraph (b), increases in the Colorado indigent care program payments made pursuant to subparagraph (II) of this paragraph (b), and quality incentive payments made pursuant to subparagraph (III) of this paragraph (b);

(E) The ~~state department's~~ ENTERPRISE'S actual costs for the changes and updates to the Colorado benefits management system and medicaid management information system to implement and maintain the expanded eligibility provided for in subparagraphs (IV) and (V) of this paragraph (b);

(F) The ~~state department's~~ ENTERPRISE'S personal services and operating costs related to personnel necessary to implement and administer the expanded eligibility for public medical assistance provided for in subparagraphs (IV) and (V) of this paragraph (b), including but not limited to administrative costs associated with the determination of eligibility for public medical assistance by county departments;

(G) The ~~state department's~~ ENTERPRISE'S personal services, operating, and systems costs related to expanding the opportunity for individuals to apply for public medical assistance directly at hospitals or through another entity outside the county departments, in connection with section 25.5-4-205, that would increase access to public medical assistance and reduce the number of uninsured served by hospitals; and

(5) **Appropriations.** (a) (I) The provider fee ~~is~~ AND THE NEW PROVIDER FEE ARE to supplement, not supplant, general fund appropriations to support hospital reimbursements as of July 1, 2009. General fund appropriations for hospital reimbursements shall be maintained at the level of appropriations in the medical services premium line item made for the fiscal year commencing July 1, 2008; except that general fund appropriations for hospital reimbursements may be reduced if an index of appropriations to other providers shows that general fund appropriations are reduced for other providers. If the index shows that general fund appropriations are reduced for other providers, the general fund appropriations for hospital reimbursements shall not be reduced by a greater percentage than the reductions of appropriations for the other providers as shown by the index.

(b) If the revenue from the provider fee, OR ON AND AFTER JULY 1, 2016, THE NEW PROVIDER FEE, is insufficient to fully fund all of the

purposes described in paragraph (b) of subsection (4) of this section:

(II) The hospital provider reimbursement and quality incentive payment increases described in subparagraphs (I) to (III) of paragraph (b) of subsection (4) of this section and the costs described in subparagraphs (VI) and (VII) of paragraph (b) of subsection (4) of this section shall be fully funded using ANY UNSPENT revenue from the provider fee COLLECTED BEFORE JULY 1, 2016, REVENUE FROM THE NEW PROVIDER FEE, and federal matching funds before any eligibility expansion is funded; and

(III) (A) If the state board promulgates rules that expand eligibility for medical assistance to be paid for pursuant to subparagraph (IV) of paragraph (b) of subsection (4) of this section and the state department thereafter notifies the ~~advisory board~~ ENTERPRISE that the revenue available from ~~the~~ ANY UNSPENT provider fee COLLECTED BEFORE JULY 1, 2016, THE NEW PROVIDER FEE, and the federal matching funds will not be sufficient to pay for all or part of the expanded eligibility, the ~~advisory board~~ ENTERPRISE shall recommend to the state board reductions in medical benefits or eligibility so that the revenue will be sufficient to pay for all of the reduced benefits or eligibility. After receiving the recommendations of the ~~advisory board~~ ENTERPRISE, the state board shall adopt rules providing for reduced benefits or reduced eligibility for which the revenue shall be sufficient and shall forward any adopted rules to the joint budget committee. Notwithstanding the provisions of section 24-4-103 (8) and (12), C.R.S., following the adoption of rules pursuant to this sub-subparagraph (A), the state board shall not submit the rules to the attorney general and shall not file the rules with the secretary of state until the joint budget committee approves the rules pursuant to

sub-subparagraph (B) of this subparagraph (III).

(B) The joint budget committee shall promptly consider any rules adopted by the state board pursuant to sub-subparagraph (A) of this subparagraph (III). The joint budget committee shall promptly notify THE ENTERPRISE, the state department, AND the state board ~~and the advisory board~~ of any action on such rules. If the joint budget committee does not approve the rules, the joint budget committee shall recommend a reduction in benefits or eligibility so that ~~the~~ ANY UNSPENT revenue from the provider fee COLLECTED BEFORE JULY 1, 2016, THE NEW PROVIDER FEE, and the matching federal funds will be sufficient to pay for the reduced benefits or eligibility. After approving the rules pursuant to this sub-subparagraph (B), the joint budget committee shall request that the committee on legal services, created pursuant to section 2-3-501, C.R.S., extend the rules as provided for in section 24-4-103 (8), C.R.S., unless the committee on legal services finds after review that the rules do not conform with section 24-4-103 (8) (a), C.R.S.

(c) Notwithstanding any other provision of this section, if, after receipt of authorization to receive federal matching funds for moneys in the fund, the authorization is withdrawn or changed so that federal matching funds are no longer available, the ~~state department~~ ENTERPRISE shall cease collecting the NEW provider fee and shall repay to the hospitals any moneys received by the fund that are not subject to federal matching funds.

(6) **Health care affordability enterprise board.** (a) ~~There is hereby created in the state department the hospital provider fee oversight and advisory board, referred to in this section as the "advisory board".~~

(b) (I) EXCEPT AS OTHERWISE PROVIDED IN SUBPARAGRAPH (I.5)

OF THIS PARAGRAPH (b), the ~~advisory board shall consist~~ ENTERPRISE BOARD CONSISTS of thirteen members appointed by the governor, with the advice and consent of the senate, as follows:

(I.5) THE INITIAL MEMBERS OF THE ENTERPRISE BOARD ARE THE MEMBERS OF THE HOSPITAL PROVIDER FEE OVERSIGHT AND ADVISORY BOARD THAT WAS CREATED AND EXISTED PURSUANT TO THIS SUBSECTION (6) PRIOR TO JULY 1, 2016, AND SUCH MEMBERS SHALL SERVE ON AND AFTER JULY 1, 2016, FOR THE REMAINDER OF THE TERMS FOR WHICH THEY WERE APPOINTED AS MEMBERS OF THE ADVISORY BOARD. THE POWERS, DUTIES, AND FUNCTIONS OF THE HOSPITAL PROVIDER FEE OVERSIGHT AND ADVISORY BOARD ARE TRANSFERRED BY A **TYPE 3** TRANSFER, AS DEFINED IN SECTION 24-1-105, C.R.S., TO THE ENTERPRISE, AND THE HOSPITAL PROVIDER FEE OVERSIGHT AND ADVISORY BOARD IS ABOLISHED.

(II) The governor shall consult with representatives of a statewide organization of hospitals in making the appointments pursuant to sub-subparagraphs (A) and (B) of subparagraph (I) of this paragraph (b). No more than six members of the ~~advisory~~ ENTERPRISE board may be members of the same political party.

(III) Members of the ~~advisory~~ ENTERPRISE board ~~shall~~ serve at the pleasure of the governor. ~~In making the appointments, the governor shall specify that four members shall serve initial terms of two years and three members shall serve initial terms of three years.~~ All ~~other~~ terms ~~including terms after the initial terms shall be~~ ARE FOR four years. A member who is appointed to fill a vacancy shall serve the remainder of the unexpired term of the former member.

(IV) The governor shall designate a chair from among the members of the ~~advisory~~ ENTERPRISE board appointed pursuant to

sub-subparagraphs (A) to (G) of subparagraph (I) of this paragraph (b). The ~~advisory~~ ENTERPRISE board shall elect a vice-chair from among its members.

(c) Members of the ~~advisory~~ ENTERPRISE board ~~shall~~ serve without compensation but shall be reimbursed from moneys in the fund for actual and necessary expenses incurred in the performance of their duties pursuant to this section.

(d) The ~~advisory~~ ENTERPRISE board may ~~direct the state department to~~ contract for a group facilitator to assist the members of the ~~advisory~~ ENTERPRISE board in performing their required duties.

(e) The ~~advisory~~ ENTERPRISE board ~~shall have~~ HAS, at a minimum, the following duties:

(I) To ~~recommend to the state department~~ DETERMINE the timing and method by which the ~~state department~~ ENTERPRISE shall assess the NEW provider fee and the amount of the fee;

(II) If requested by the health and human services committees of the senate or house of representatives, or any successor committees, to consult with the committees on any legislation that may impact the NEW provider fee or hospital reimbursements established pursuant to this section;

(III) To ~~recommend to the state department~~ DETERMINE changes in the NEW provider fee that increase the number of hospitals benefitting from the uses of the NEW provider fee described in subparagraphs (I) to (V) of paragraph (b) of subsection (4) of this section or that minimize the number of hospitals that suffer losses as a result of paying the NEW provider fee;

(VIII) To monitor the impact of the NEW hospital provider fee on

the broader health care marketplace; ~~and~~

(VIII.5) TO ESTABLISH REQUIREMENTS FOR THE REPORTS THAT HOSPITALS MUST SUBMIT TO THE ENTERPRISE TO ALLOW THE ENTERPRISE TO CALCULATE THE AMOUNT OF THE NEW PROVIDER FEE; AND

(IX) To perform any other duties required to fulfill the ~~advisory~~ ENTERPRISE board's charge or those assigned to it by the state board or the executive director.

(f) On or before ~~January 15, 2010~~ JANUARY 15, 2017, and on or before January 15 each year thereafter, the ~~advisory~~ ENTERPRISE board shall submit a written report to the health and human services committees of the senate and the house of representatives, or any successor committees, the joint budget committee of the general assembly, the governor, and the state board. The report shall include, but need not be limited to:

(II) A description of the formula for how the NEW provider fee is calculated and the process by which the NEW provider fee is assessed and collected;

(III) An itemization of the total amount of the NEW provider fee paid by each hospital and any projected revenue that each hospital is expected to receive due to:

(IV) An itemization of the costs incurred by the ~~state department~~ ENTERPRISE in implementing and administering the NEW hospital provider fee; and

(g) ~~(I) This subsection (6) is repealed, effective July 1, 2019.~~

~~(II) Prior to said repeal, the advisory board shall be reviewed as provided in section 2-3-1203, C.R.S.~~

(h) (I) THE ENTERPRISE IS SUBJECT TO THE OPEN MEETINGS

PROVISIONS OF THE "COLORADO SUNSHINE ACT OF 1972" CONTAINED IN PART 4 OF ARTICLE 6 OF TITLE 24, C.R.S., AND THE "COLORADO OPEN RECORDS ACT", PART 2 OF ARTICLE 72 OF TITLE 24, C.R.S.

(II) FOR PURPOSES OF THE "COLORADO OPEN RECORDS ACT", PART 2 OF ARTICLE 72 OF TITLE 24, C.R.S., AND EXCEPT AS MAY OTHERWISE BE PROVIDED BY FEDERAL LAW OR REGULATION OR STATE LAW, THE RECORDS OF THE ENTERPRISE ARE PUBLIC RECORDS, AS DEFINED IN SECTION 24-72-202 (6), C.R.S., REGARDLESS OF WHETHER THE ENTERPRISE RECEIVES LESS THAN TEN PERCENT OF ITS TOTAL ANNUAL REVENUES IN GRANTS, AS DEFINED IN SECTION 24-77-102 (7), C.R.S., FROM ALL COLORADO STATE AND LOCAL GOVERNMENTS COMBINED.

(III) THE ENTERPRISE IS A PUBLIC ENTITY FOR PURPOSES OF PART 2 OF ARTICLE 57 OF TITLE 11, C.R.S.

SECTION 2. In Colorado Revised Statutes, 24-1-119.5, **add** (9) as follows:

24-1-119.5. Department of health care policy and financing - creation. (9) THE HEALTH CARE AFFORDABILITY ENTERPRISE CREATED IN SECTION 25.5-4-402.3 (2.5), C.R.S., SHALL EXERCISE ITS POWERS AND PERFORM ITS DUTIES AND FUNCTIONS AS IF THE SAME WERE TRANSFERRED BY A **TYPE 2** TRANSFER, AS DEFINED IN SECTION 24-1-105, TO THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING.

SECTION 3. In Colorado Revised Statutes, **amend** 2-3-119 as follows:

2-3-119. Audit of new hospital provider fee - cost shift. ~~Starting with the second full state fiscal year following the receipt of the notice from the executive director of the department of health care policy and financing pursuant to section 25.5-4-402.3 (7), C.R.S., and thereafter~~ At

the discretion of the legislative audit committee, the state auditor shall conduct or cause to be conducted a performance and fiscal audit of the NEW hospital provider fee established pursuant to section 25.5-4-402.3, C.R.S.

SECTION 4. In Colorado Revised Statutes, 2-3-1203, **repeal** (3) (ff) (V) as follows:

2-3-1203. Sunset review of advisory committees. (3) (ff) July 1, 2019:

(V) ~~The hospital provider fee oversight and advisory board, created in section 25.5-4-402.3, C.R.S.;~~

SECTION 5. In Colorado Revised Statutes, 25.5-5-201, **amend** (1) (o) (II) and (1) (r) (II) as follows:

25.5-5-201. Optional provisions - optional groups - repeal. (1) The federal government allows the state to select optional groups to receive medical assistance. Pursuant to federal law, any person who is eligible for medical assistance under the optional groups specified in this section shall receive both the mandatory services specified in sections 25.5-5-102 and 25.5-5-103 and the optional services specified in sections 25.5-5-202 and 25.5-5-203. Subject to the availability of federal financial aid funds, the following are the individuals or groups that Colorado has selected as optional groups to receive medical assistance pursuant to this article and articles 4 and 6 of this title:

(o) (II) Notwithstanding the provisions of subparagraph (I) of this paragraph (o), if the moneys in the NEW hospital provider fee cash fund established pursuant to section 25.5-4-402.3 (4), together with the corresponding federal matching funds, are insufficient to fully fund all of the purposes described in section 25.5-4-402.3 (4) (b), after receiving

recommendations from the ~~hospital provider fee oversight and advisory board~~ HEALTH CARE AFFORDABILITY ENTERPRISE established pursuant to section 25.5-4-402.3 (2.5), for individuals with disabilities who are participating in the medicaid buy-in program established in part 14 of article 6 of this title, the state board by rule adopted pursuant to the provisions of section 25.5-4-402.3 (5) (b) (III) may reduce the medical benefits offered or the percentage of the federal poverty line to below four hundred fifty percent or may eliminate this eligibility group.

(r) (II) Notwithstanding the provisions of subparagraph (I) of this paragraph (r), if the moneys in the NEW hospital provider fee cash fund established pursuant to section 25.5-4-402.3 (4), together with the corresponding federal matching funds, are insufficient to fully fund all of the purposes described in section 25.5-4-402.3 (4) (b), after receiving recommendations from the ~~hospital provider fee oversight and advisory board~~ HEALTH CARE AFFORDABILITY ENTERPRISE established pursuant to section 25.5-4-402.3 (2.5), for persons eligible for a medicaid buy-in program established pursuant to section 25.5-5-206, the state board by rule adopted pursuant to the provisions of section 25.5-4-402.3 (5) (b) (III) may reduce the medical benefits offered, or the percentage of the federal poverty line, or may eliminate this eligibility group.

SECTION 6. In Colorado Revised Statutes, 25.5-5-204.5, **amend** (2) as follows:

25.5-5-204.5. Continuous eligibility - children - repeal. (2) Notwithstanding the provisions of subsection (1) of this section, if the moneys in the NEW hospital provider fee cash fund established pursuant to section 25.5-4-402.3 (4), together with the corresponding federal matching funds, are insufficient to fully fund all of the purposes described

in section 25.5-4-402.3 (4) (b), after receiving recommendations from the ~~hospital provider fee oversight and advisory board~~ HEALTH CARE AFFORDABILITY ENTERPRISE established pursuant to section 25.5-4-402.3 (2.5), the state board by rule adopted pursuant to the provisions of section 25.5-4-402.3 (5) (b) (III) may eliminate the continuous enrollment requirement pursuant to this section.

SECTION 7. In Colorado Revised Statutes, 25.5-8-103, **amend** (4) (a) (II) and (4) (b) (II) as follows:

25.5-8-103. Definitions - repeal. As used in this article, unless the context otherwise requires:

(4) "Eligible person" means:

(a) (II) Notwithstanding the provisions of subparagraph (I) of this paragraph (a), if the moneys in the NEW hospital provider fee cash fund established pursuant to section 25.5-4-402.3 (4), together with the corresponding federal matching funds, are insufficient to fully fund all of the purposes described in section 25.5-4-402.3 (4) (b), after receiving recommendations from the ~~hospital provider fee oversight and advisory board~~ HEALTH CARE AFFORDABILITY ENTERPRISE established pursuant to section 25.5-4-402.3 (2.5), for persons less than nineteen years of age, the state board may by rule adopted pursuant to the provisions of section 25.5-4-402.3 (5) (b) (III) reduce the percentage of the federal poverty line to below two hundred fifty percent, but the percentage shall not be reduced to below two hundred five percent.

(b) (II) Notwithstanding the provisions of subparagraph (I) of this paragraph (b), if the moneys in the NEW hospital provider fee cash fund established pursuant to section 25.5-4-402.3 (4), together with the corresponding federal matching funds, are insufficient to fully fund all of

the purposes described in section 25.5-4-402.3 (4) (b), after receiving recommendations from the ~~hospital provider fee oversight and advisory board~~ HEALTH CARE AFFORDABILITY ENTERPRISE established pursuant to section 25.5-4-402.3 (2.5), for pregnant women, the state board by rule adopted pursuant to the provisions of section 25.5-4-402.3 (5) (b) (III) may reduce the percentage of the federal poverty line to below two hundred fifty percent, but the percentage shall not be reduced to below two hundred five percent.

SECTION 8. Effective date. (1) Except as otherwise provided in this section, this act takes effect July 1, 2016.

(2) (a) This act does not take effect if the centers for medicare and medicaid services determine that the amendments set forth in this act do not comply with federal law.

(b) If the centers for medicare and medicaid services make the determination described in paragraph (a) of this subsection (2), the executive director of the department of health care policy and financing shall, no later than June 1, 2016, notify the revisor of statutes in writing of that determination.

SECTION 9. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.