HB09-1293

Colorado Legislative Council Staff Fiscal Note

STATE and LOCAL FISCAL IMPACT

Drafting Number:	LLS 09-0847	**Date:**	March 12, 2009
Prime Sponsor(s):	Rep. Riesberg; Ferrandino Sen. Keller	**Bill Status:** **Fiscal Analyst:**	House Health and Human Services Amy Larsen (303-866-3488)

TITLE: CONCERNING A HOSPITAL PROVIDER FEE, AND, IN CONNECTION THEREWITH, AUTHORIZING THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING TO CHARGE AND COLLECT A HOSPITAL PROVIDER FEE AND SPECIFYING THE ALLOWABLE USES OF THE FEES.

Fiscal Impact Summary	FY 2009-2010*	FY 2010-2011*
State Revenue		
Cash Funds		
Hospital Provider Fee Cash Fund	$1.5 million	$251.3 million
Children Basic Health Plan Trust - Cost Sharing	0	0.3 million
State Expenditures		
Total	$4.6 million	$522.4 million
General Fund**	1.5 million	0
Cash Funds		
Hospital Provider Fee Cash Fund	1.5 million	251.3 million
Children's Basic Health Plan Trust	0	0.3 million
Local Funds	0	0.4 million
Federal Funds	3.1 million	270.5 million
FTE Position Change	9.5 FTE	41.0 FTE
Effective Date: Upon signature of the Governor or upon becoming law without his signature. See also Summary of Legislation section for additional information.		
Appropriation Summary for FY 2009-2010: See State Appropriations section.		
Local Government Impact: See Local Government Impact section.		

**** State revenue for FY 2009-10 and both revenue and expenditures for FY 2010-11 are conditional upon federal approval of a hospital provider fee and related expenditures as outlined in the bill.***

***** General Fund is only required if the hospital provider fee is not approved. The need for General Fund is based on HB08-1114 which authorized a nursing home quality assurance fee, and includes two appropriations in the event that the fee is not approved, one from cash funds and one from General Fund.***

Summary of Legislation

The bill creates the Health Care Affordability Act of 2009. The Department of Health Care Policy and Financing (DHCPF) is authorized to collect hospital provider fees for the purpose of obtaining federal financial participation for the state's medical assistance programs. Fees are set by the State Medical Services Board based on federal regulations and are for the following:

- to increase reimbursements to hospitals;
- to increase the number of people covered by medical assistance programs; and
- to pay for administrative costs related to the fee and program expansions.

Payments to Hospitals. Subject to the receipt of federal authorization, state payments to hospitals will increase through (1) maximizing provider payments based on federal regulations, (2) increasing payments under the Colorado Indigent Care Program (CICP) to 100 percent of cost, and (3) paying a new quality incentive payment.

Expanding Medical Assistance Programs. If sufficient fees and federal funding are available, the bill allows the DHCPF to expand medical assistance programs as follows:

- Children's Basic Health Plan (CBHP) up to 250 percent of the federal poverty level (FPL) for both children and pregnant women, the current level is 205 percent FPL;
- Medicaid for parents up to 100 percent FPL, the current level is 60 percent FPL;
- 12-month continuous eligibility for children in Medicaid;
- a new Medicaid buy-in program for disabled adults and children with income up to 400 percent FPL; and
- a new medical assistance program for childless adults with income up to 100 percent FPL.

Funding. The revenue generated by the hospital provider fee is to supplement current General Fund appropriations to support hospitals. If revenue from the fee is insufficient to fully fund the items listed above, the General Assembly is not obligated to appropriate General Fund. Payments to hospitals must be fully funded before any eligibility expansion. The State Medical Services Board is authorized to set rules related to the fee and expansion programs, but rules to reduce medical benefits or eligibility must be approved by the Joint Budget Committee.

Advisory Board. The 11-member Hospital Provider Fee Oversight and Advisory Board is established to provide recommendations to the DHCPF and the State Medical Services Board regarding the implementation of the fee and the expansion programs. The advisory board also reports to the General Assembly.

Effective Date. The bill specifies that sections of the bill to increase payments to hospitals and expansions of medical assistance programs are effective July 1 of the fiscal year following the receipt of federal authorization to receive federal matching funds. If federal authority is not received by July 1, 2012, the bill is repealed.

State Revenue

State cash funds revenue is expected to increase by $1.5 million in FY 2009-10, $251.6 million in FY 2010-11, $345.4 million in FY 2011-12, and $482.4 million in FY 2012-13. Revenue is from fees charged to hospitals and cost sharing for the CBHP as discussed below, and is conditional upon federal approval.

Fee Impact on Individuals, Families or Business. Section 2-2-322, C.R.S., requires legislative service agency review of measures which create or increase any fee collected by a state agency. The table below identifies the fee impact of this bill.

Table 1. Fee Impact on Hospitals*

Size of Facility - Beds	Less than 25	25-99	100-300	More than 300	Total
Number of Facilities	15	13	23	33	84
FY 2009-10 Total Fees	$30,520	$76,300	$457,797	$961,374	**$1,525,990**
Average per Facility	$925	$3,317	$35,215	$64,092	
FY 2010-11 Total Fees	$5,025,226	$12,563,066	$75,378,396	$158,294,633	**$251,261,321**
Average per Facility	$152,280	$546,220	$5,798,338	$10,552,976	
FY 2011-12 Total Fees	$6,901,714	$17,254,286	$103,525,717	$217,404,005	**$345,085,722**
Average per Facility	$209,143	$750,186	$7,963,517	$14,493,600	
FY 2012-13 Total Fees	$9,639,069	$24,097,673	$144,586,036	$303,630,677	**$481,953,455**
Average per Facility	$292,093	$1,047,725	$11,122,003	$20,242,045	

** Estimates of fee revenue by the size of hospital are included for illustrative purposes; actual fees will be set by the State Medical Services Board.*

The bill authorizes the DHCPF to collect hospital provider fees beginning in FY 2009-10, once federal approval is received. Federal law limits hospital provider fees to 5.5 percent of aggregate net revenue, but estimates included in the fiscal note are less than 3.0 percent. The State Medical Services Board must adopt rules related to the fee, including exempting or reducing the fee for some hospitals. For some hospitals, the fee charged under HB09-1293 will be more than the increase in payments described in the State Expenditures section. The fee is expected to vary significantly among hospitals based on size and net revenue of individual facilities.

Anticipated fee revenue is based on state costs to fully implement HB09-1293 as outlined in the State Expenditures section and will continue to increase in out-years as program expansions are phased-in. The bill requires the department to make additional payments to hospitals within 2 days of the payment of fees which will lessen cash flow concerns for hospitals.

CBHP Fee. State revenue from CBHP fees is expected to increase by $254,751 in FY 2010-11 and by $327,537 in FY 2011-12. Annual enrollment fees are collected from families with total income above 150 percent FPL participating in CBHP. Increased enrollment in the program results in increased fees. Families are currently charged $25 per year for one child in the program and $35 for 2 or more children.

State Expenditures

For FY 2009-10, state expenditures for the DHCPF are expected to increase by $4.6 million and 9.5 FTE, split between the Hospital Provider Fee Cash Fund ($1.5 million) and federal funds ($1.6 million). **Costs to implement the hospital provider fee and expansion programs will begin**

July 1, 2009, and the fiscal note assumes that federal approval will be received in sufficient time to assess and collect hospital provider fees in FY 2009-10 to cover state costs. If federal approval is not received, General Fund or other state funds will be required.

For FY 2010-11, expenditures are expected to increase by $533.6 million and 41.0 FTE split between cash funds ($257.5 million) and federal funds ($276.1 million). **These expenditures are conditional upon federal approval of the hospital provider fee and program expansions defined in the bill.**

Key Assumptions. This fiscal note is based on the following key assumptions:

- federal approval of the hospital provider fee will be received in spring 2010;
- the State Medical Services Board will establish rules based on the requirements of the bill and federal regulations to cover anticipated expenditures for increased reimbursement of hospitals, program expansions, and related administrative costs;
- the DHCPF will begin administrative and computer system changes in FY 2009-10 to allow for increased hospital reimbursement and program expansion to begin July 1, 2010; and
- state funding to begin administrative and computer system changes in FY 2009-10 will be from the Hospital Provider Fee Cash Fund, but if the fee is not approved, other state funds will be required.

Anticipated costs are summarized in Table 2 followed by discussions of the increase in payments to hospitals and each program expansion.

Table 2. Total Expenditures Under HB09-1293

Cost Components	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
Payments to Hospitals	$1,351,576	$364,451,548	$383,713,808	$405,083,052
CBHP Expansion to 250% FPL	161,650	52,890,522	70,845,006	82,009,995
Medicaid Expansion - Parents to 100%	237,300	90,651,161	121,373,511	140,455,957
Medicaid Continuous Eligibility	211,806	423,612	24,464,990	75,861,294
Medicaid Buy-in to 400% FPL	171,604	1,644,432	37,263,212	75,786,238
Medicaid Expansion - Childless Adults	0	2,804,698	64,195,384	197,366,991
Department Administration	2,461,040	9,494,103	11,809,500	13,026,925
Total	**$4,594,976**	**$522,360,076**	**$713,665,411**	**$989,590,452**
Hospital Provider Fee Cash Fund	**1,525,990**	**251,261,322**	**345,085,723**	**481,953,455**
CBHP Trust - Fees	**0**	**254,751**	**327,537**	**363,930**
Local Funds	**0**	**374,366**	**472,297**	**506,213**
Federal Funds	**3,068,986**	**270,469,637**	**367,779,854**	**506,756,854**

Payments to Hospitals. HB09-1293 allows for increased reimbursement rates to hospitals and a new payment based on performance. The bill specifies that inpatient and outpatient hospital Medicaid reimbursement rates are to be maximized up to federal limits. For inpatient hospitals, this would increase the state's reimbursement up to the Medicare rate; the state currently pays 90- 92 percent of the Medicare rate. For outpatient hospitals, the state's reimbursement will increase from 72 percent of costs up to 100 percent.

Reimbursements for the CICP are also expected to increase to 100 percent of costs. This payment will reduce expenditures currently considered uncompensated care which will also reduce reimbursements to hospitals for this care known as certified public expenditures. In addition to these rate increases, a new hospital payment will be implemented up to 7 percent of total reimbursements and based on performance. Payments to hospitals are to occur within 2 days of when hospitals are required to pay their fee to the state.

Costs are included for hospital payment increases as well as administrative costs to update the rate setting method for inpatient, outpatient, and rehabilitation hospitals and to make modifications to the Medicaid Management Information System. Other administrative costs include: annual hospital survey costs, Hospital Provider Fee Oversight and Advisory Board expenses, and increased auditing of the CICP.

Table 3. Payments to Hospitals Under HB09-1293

Cost Components	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
Inpatient Hospital Rates to Medicare Rate		$79,032,870	$82,403,622	$85,918,136
Outpatient Hospital Rates to 100% of Cost		71,108,730	74,141,517	77,303,653
Performance and Supplemental Payments		153,269,550	159,806,496	166,622,243
CICP Rates to 100% of Cost		335,941,830	350,269,749	365,208,754
Reduced Certified Public Expenditures		(276,730,242)	(283,620,826)	(290,682,984)
Administrative Costs	$1,351,576	1,828,810	713,250	713,250
Total	**$1,351,576**	**$364,451,548**	**$383,713,808**	**$405,083,052**
Hospital Provider Fee Cash Fund	**378,082**	**181,971,884**	**191,856,904**	**202,541,526**
Federal Funds	**973,495**	**182,479,664**	**191,856,904**	**202,541,526**

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CBHP Expansion to 250 percent FPL. The bill increases income eligibility for the CBHP from 205 to 250 percent FPL. Based on the number of uninsured children in Colorado and a gradual increase in program enrollment beginning July 2010, caseload increases are expected to increase to 21,400 children and 2,600 pregnant women by FY 2013-14. The expansion population is expected to receive the same benefits as clients currently eligible. For FY 2010-11, per capita costs are $2,180 for children and $11,322 for pregnant women. Total expenditures are summarized in Table 4.

Table 4. Costs to Expand CBHP Eligibility to 250% FPL

Cost Components	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
Children - Medical & Dental		$32,043,354	$42,955,731	$49,764,120
Caseload		14,700	18,900	21,000
Pregnant Women - Medical		$19,813,868	$26,561,475	$30,771,475
Caseload		1,750	2,250	2,500
Administration Costs*	$161,650	$1,033,300	$1,327,800	$1,474,400
TOTAL	**$161,650**	**$52,890,522**	**$70,845,006**	**$82,009,995**
Hospital Provider Fee CF	**53,202**	**18,510,175**	**24,664,844**	**24,664,844**
CBHP Trust - Fees	**0**	**305,411**	**392,677**	**392,677**
Federal Funds	**108,448**	**34,074,936**	**45,787,485**	**45,787,485**

** Administration costs include the following: Colorado Benefits Management System, Medicaid Management Information System, county administration, enrollment vendor, and external quality review.*

Medicaid Expansion - Parents to 100 Percent FPL. Currently, parents of children who are eligible for Medicaid are also eligible if family income is less than 60 percent FPL. HB09-1293 increases income eligibility to 100 percent FPL. Costs are included for administration and systems changes beginning in FY 2009-10. Implementation is expected July 1, 2010. Anticipated caseload is based on The Lewin Group estimates and is expected to phase-in over 3 years, reaching 43,000 by FY 2012-13. Per capita costs are assumed to be the same as the lower income group, currently $2,800 per year. Costs are summarized in Table 5.

Table 5. Costs to Expand Medicaid Eligibility for Parents to 100% FPL

Cost Components	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
Medical Services Premiums and Mental Health Services		$88,848,879	$119,106,603	$137,984,850
Caseload		30,100	38,700	43,000
Administration Costs*	$237,300	$1,802,282	$2,266,908	$2,471,107
TOTAL	**$237,300**	**$90,651,161**	**$121,373,511**	**$140,455,957**
Hospital Provider Fee CF	**70,135**	**45,082,802**	**60,381,388**	**69,895,104**
Local Funds	**0**	**323,706**	**407,157**	**443,833**
Federal Funds	**167,165**	**45,244,654**	**60,584,966**	**70,117,020**

** Administration costs include the following: Colorado Benefits Management System, Medicaid Management Information System, county administration, and an enrollment vendor.*

Medicaid 12-month Continuous Eligibility for Children. The bill implements 12-month eligibility for Medicaid clients under the age of 19. This is expected to increase the average length of participation for most Medicaid children from 8.5 to 10.7 months, a 25.4 percent increase. The increase for foster care children is estimated at 23.7 percent. The fiscal note assumes that per capita medical costs will be 25 percent less for all children in the extended time period since any pent-up demand for services will already be met. Due to the complex computer systems changes that are required, implementation of this provision is expected in February 2012. Medicaid caseload is expected to increase by 13,250 children in FY 2011-12, based on 5 months of implementation. Full implementation in FY 2013-14 is expected to increase caseload by 48,500.

Since the CBHP currently has 12-month eligibility, its caseload is expected to decrease since more children will remain in or return to Medicaid. The length of participation in the CBHP and Medicaid is expected to equalize at 10.7 months. Thus, the fiscal note assumes that CBHP participation will reduce from 11.3 to 10.7 months. Reduced caseloads of 875 in FY 2011-12, 2,625 in FY 2012-13, and 3,500 in FY 2013-14 are anticipated. Resulting net costs, including computer system changes, are shown in Table 6.

Table 6. Costs for 12-month Continuous Medicaid Eligibility for Children

Cost Components	FY 2009-10	FY 2010-11	FY 2011-12		FY 2012-13	
	Cost	Cost	Caseload	Cost	Caseload	Cost
Medicaid Premiums			13,250	$26,241,876	36,375	$82,081,810
CBHP Costs (Savings)			(875)	(1,988,692)	(2,625)	(6,220,516)
Computer Systems Costs	$211,806	$423,612		211,806		0
TOTAL	**$211,806**	**$423,612**	**12,375**	**24,464,990**	**33,750**	**$75,861,294**
Hospital Provider Fee CF	**90,667**	**181,335**		**12,515,563**		**38,863,724**
Federal Funds	**121,139**	**242,277**		**11,949,427**		**36,997,570**

Medicaid Buy-in to 400 percent FPL. The bill allows for a Medicaid buy-in program for disabled children and adults with family income up to 400 percent FPL. Participants must pay a premium pursuant to a sliding payment schedule to be established by the State Medical Services Board. Enrollment in the program is expected to begin in July 2011, once federal approval is received and computer systems changes are complete.

Caseload estimates are based on data provided by The Lewin Group, and caseload is expected to phase in over three years reaching 9,000 clients in FY 2013-14. Per capita costs are assumed to be equal to costs for Medicaid disabled individuals under the age of 60 reduced by client payments between 4.5 and 5.5 percent of income. State per capita costs of $7,820 are anticipated for FY 2011-12. Costs are summarized in Table 7.

Table 7. Costs for Medicaid Buy-in for the Disabled

Cost Components	FY 2009-10	FY 2010-11	FY 2011-12		FY 2012-13	
	Cost	Cost	Caseload	Cost	Caseload	Cost
Premium Subsidy			3,600	$34,827,012	7,200	$73,116,576
Computer Systems Costs	$171,604	$1,644,432		2,436,200		2,669,662
TOTAL	**$171,604**	**$1,644,432**	**3,600**	**37,263,212**	**7,200**	**$75,786,238**
Hospital Provider Fee CF	**54,260**	**538,343**		**18,631,606**		**37,893,119**
Federal Funds	**117,344**	**1,106,089**		**18,631,606**		**37,893,119**

Medicaid Expansion - Childless Adults to 100 percent FPL. The bill allows Medicaid to be expanded to include childless adults with income up to 100 percent FPL. In order to meet federal requirements for budget neutrality, it is assumed that this group will receive a smaller benefit package than traditional Medicaid and that hospitals will have reduced uncompensated care when low-income adults have this coverage. These clients are also expected to have co-payments for services. Enrollment in the program is expected to begin in January 2012, once federal approval is received and computer systems changes are complete.

Anticipated caseload is based on the number of uninsured, income data provided by The Lewin Group, and a three year phase-in. Caseload is expected to reach 82,000 by FY 2013-14. Estimated per capita medical payments are $3,500 per year. Costs are also included for computer systems changes, benefits development and review, and an eligibility vendor. Expenditures are summarized in Table 8.

Table 8. Costs for Medicaid Expansion to Childless Adults

Cost Components	FY 2009-10	FY 2010-11	FY 2011-12		FY 2012-13	
	Cost	Cost	Caseload	Cost	Caseload	Cost
Medical Services			16,400	$62,045,300	49,200	$194,074,320
Administrative Costs				1,215,184		3,292,671
Computer Systems Costs		$2,804,698		934,900		0
TOTAL	**$0**	**$2,804,698**	**16,400**	**64,195,384**	**49,200**	**$197,366,991**
Hospital Provider Fee CF	**0**	**803,924**		**31,898,217**		**98,683,496**
Federal Funds	**0**	**2,000,774**		**32,297,167**		**98,683,496**

Department Administration. In addition to the administrative expenses identified above, costs are anticipated to support the hospital provider fee and all of the Medicaid and the CBHP expansions. Once fully implemented, the DHCPF is expected to increase its caseload served and total budget by about 25 percent. Thus, workload will increase in nearly every division and office, and personal services (FTE) are required. The fiscal note includes personal services, standard operating, capital, leased space, and supplemental retirement payments for 9.5 FTE in FY 2009-10 increasing to 57.0 FTE in FY 2011-12 and subsequent years. Detailed information for each FTE is available in the Legislative Council Staff, fiscal note section.

The DHCPF currently contracts with Denver Health and Children's Hospital to assist with client enrollment. The department is expected to expand this program to other interested hospitals. Costs are based on $36,600 for each hospital ($3.1 million total), but hospitals with more Medicaid clients will receive more than lower volume hospitals. Other expenses to support the requirements of HB09-1293 include ongoing maintenance and reporting requirements for computer systems, legal services, third-party recovery, administrative law judge services, and labor costs for office set-up.

In FY 2009-10, 100 percent of costs are administrative in nature, but beginning in FY 2012-13, administrative costs shown in Table 9 and those listed with each expansion are less than 3 percent of total expenditures under HB09-1293.

Table 9. Department of Health Care Policy and Financing
Administrative Expenses Under HB09-1293

Cost Components	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
Personal Services and Operating Expenses	$753,885	$2,774,643	$3,694,722	$3,611,074
FTE	9.5	41.0	57.0	57.0
Hospitals - Client Enrollment	0	3,074,400	3,074,400	3,074,400
Computer Systems	1,523,503	2,716,666	3,941,185	5,193,198
Legal/Administrative Law Judge Services	0	88,474	168,667	280,385
Leased Space, Employee Insurance, and Supplemental Retirement Benefits	183,652	839,920	930,526	867,869
Total	**$2,461,040**	**$9,494,103**	**$11,809,500**	**$13,026,926**
Hospital Provider Fee Cash Fund	**879,644**	**4,172,860**	**5,137,200**	**5,518,454**
Federal Funds	**1,581,396**	**5,321,243**	**6,672,300**	**7,508,472**

Department of Human Services (DHS). Each section described above includes programing and maintenance costs for the Colorado Benefits Management System (CBMS). Cost sharing among programs in both the Department of Health Care Policy and Financing and the Department of Human Services is required and is determined using the federally-approved cost allocation tool. The fiscal note assumes that all state costs to implement changes required by HB09-1293 will be funded through the Hospital Provider Fee Cash Fund. The DHS requires an appropriation for these costs since it coordinates and oversees CBMS.

Other State Impacts

Under Referendum C, the state could begin to incur TABOR surpluses beginning in FY 2010-11. A cash funds revenue source such as the hospital provider fee, contributes to the TABOR surplus to the extent that it increases faster over time than the allowable growth rate for the Referendum C cap of inflation plus population growth. Because the General Assembly has chosen to refund the surplus out of the General Fund, cash funds revenue growth greater than the Referendum C cap reduces the amount of money available in the General Fund to pay for General Fund obligations.

The hospital provider fee is expected to increase at annual rates of between 24 and 38 percent during its phase-in period between FY 2010-11 through FY 2013-14. According to the December 2008 LCS forecast, the hospital provider fee is not expected to generate a surplus above the Referendum C cap through FY 2011-12, the end of the forecast period. However, the rapid increase of revenue expected from the fee could, in subsequent years, generate a surplus earlier than would have occurred under current law.

Local Government Impact

Local county departments of social services are expected to process and manage additional caseload as a result of this bill. Additional state payments to counties of $1.9 million are expected in FY 2010-11, increasing in out-years based on caseload.

State Appropriations

For FY 2009-10, the fiscal note indicates that the Department of Health Care Policy and Financing should receive an appropriation of $4,594,976 and 9.5 FTE. Of the total, $1,525,990 is General Fund and $3,068,986 is federal funds. This appropriation mirrors that for HB08-1114 and is not need if the hospital provider fee is approved.

Conditional upon federal approval of the hospital provider fee, the Department of Health Care Policy and Financing should receive an appropriation of $4,594,976 and 9.5 FTE, split between the Hospital Provider Fee Cash Fund ($1,525,990) and federal funds ($3,068,986).

For FY 2009-10, the Department of Human Services requires an appropriation of $324,282 (reappropriated funds) for CBMS costs.

Departments Contacted

Health Care Policy and Financing
Personnel and Administration
Treasury
Legislature - JBC Staff and LCS Economists
Human Services
Higher Education
Law