# MEMORANDUM

JOINT BUDGET COMMITTEE

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| TO | Joint Budget Committee |
| FROM | Eric Kurtz, JBC Staff (303-866-4952) |
| DATE | March 20, 2017 |
| SUBJECT | Hospital Provider Fee Restriction |

## STATUS

The JBC tabled discussion of this request from the Governor until after the March revenue forecast.

## NEW INFORMATION

The projected TABOR overage represents the maximum potential General Fund savings that could be achieved from restricting Hospital Provider Fee revenues. This is because the General Fund benefit from restricting Hospital Provider Fee revenues comes from reducing the General Fund obligation for a TABOR refund. The table below summarizes the projected TABOR overage under the revenue forecasts by Legislative Council Staff and the Office of State Planning and Budgeting.

| | TABOR Overage |
|---|---|
| Legislative Council Staff | $264,100,000 |
| Office of State Planning and Budgeting | $135,100,000 |

In November the Governor proposed a $195.0 million restriction on the Hospital Provider Fee, but under the March OSPB forecast that would only provide a General Fund savings of $135.1 million. Under the March LCS forecast the JBC could increase the restriction to $264.1 million and still get additional General Fund savings.

Representative Rankin expressed interest in mitigating the negative impact on hospitals from restricting the Hospital Provider Fee by increasing provider rates. Under the LCS forecast, the General Assembly could fully replace Hospital Provider Fee restriction with a provider rate increase and achieve very nearly the same General Fund benefit as the $195.0 million the Governor proposed in November. This would require increasing the Hospital Provider Fee restriction to $264.1 million and then spending $73.6 million General Fund for a provider rate increase that would net the hospitals $264.1 million with the favorable federal match rates available for expansion populations.

| | |
|---|---|
| Restrict Hospital Provider Fee (HPF) revenue | ($264,100,000) |
| | |
| Effect on hospitals | |
| Net loss in HPF booster payments | ($264,100,000) |
| Provider rate increase | $264,100,000 |
| Net benefit to hospitals | $0 |
| | |
| Effect on the General Fund | |
| TABOR Refund (not appropriated) | ($264,100,000) |
| GF cost of rate increase | $73,603,719 |
| Net benefit to General Fund | ($190,496,281) |

Under the OSPB forecast there is not enough of a projected TABOR refund to achieve $195.0 million in General Fund savings from a straight restriction on Hospital Provider Fee revenues, let alone to do a larger restriction to free up money for a provider rate increase that would offset the negative impact on the hospitals.

However, if the JBC does not need $195.0 million in General Fund savings and has flexibility to invest General Fund in hospital rates, then the JBC could mitigate some of the negative consequences for hospitals of a restriction on Hospital Provider Fee revenues. Every $10.0 million General Fund spent on hospital rates generates approximately $35.9 million in payments to hospitals, after accounting for the favorable federal match rates for expansion populations, and this could offset the loss of booster payments.

## COPY OF ORIGINAL STAFF RECOMMENDATION

### ➔ R1 RESTRICT HOSPITAL PROVIDER FEE REVENUE

*REQUEST:* As part of R1 the Department included a proposed $195.0 million restriction on Hospital Provider Fee revenues. The restriction would limit the ability of the Department to draw matching federal funds and the Governor describes the effect as reducing payments to hospitals by a total of $390.0 million. The purpose of the restriction is to reduce expenditures subject to the limit in Article X, Section 20 of the Colorado Constitution (TABOR) and thereby reduce the General Fund obligation for a TABOR refund.

The JBC staff is addressing this component of the request separately from the rest of R1, because it is a discretionary policy rather than a forecast change, and because the JBC staff is recommending a statutory change to implement it.

The Governor's proposed strategy for saving General Fund only works if there is a TABOR refund that can be reduced that is at least as large as the Hospital Provider Fee restriction. If the March revenue forecast shows that there is not a large enough TABOR refund that can be reduced, or if the General Assembly takes some other action to reduce TABOR revenues (such as designating the Hospital Provider Fee as an enterprise), then this strategy may not produce General Fund savings.

In the Governor's request, the reduction in Hospital Provider Fee revenues would result in lower booster payments paid from the Medical Services Premiums line item. The other major purpose of

the Hospital Provider Fee is to pay for Medicaid expansion populations and the Governor is NOT requesting any reduction to Medicaid eligibility or benefits as a result of the restriction on Hospital Provider Fee revenues.

*RECOMMENDATION:* Staff recommends that the JBC sponsor legislation to restrict Hospital Provider Fee revenues by the $195.0 million proposed by the Governor and eliminate the statutory prioritization of the uses of the Hospital Provider Fee. The staff recommendation assumes that the March revenue forecast will show at least a $195 million General Fund obligation for a TABOR refund. In December the Legislative Council Staff projected a TABOR refund obligation of $279.4 million and the Office of State Planning and Budgeting projected a TABOR refund obligation of $247.7 million. If the March revenue forecast shows less than a $195.0 million General Fund obligation for a TABOR refund, or if the General Assembly takes some other action to reduce TABOR revenues (such as designating the Hospital Provider Fee as an enterprise), then the recommended restriction on Hospital Provider Fee revenues may not be as beneficial to the budget and would need to be revisited.

The JBC staff is recommending legislation because the statutes prioritize the uses of the Hospital Provider Fee in a manner that potentially conflicts with the Governor's proposal. If revenues are insufficient, the statutory priority order places the financing of the Medicaid expansion populations last, and the Governor is not proposing a reduction in Medicaid eligibility or benefits. One of the statutory priorities before Medicaid eligibility expansions is to "maximize" inpatient and outpatient hospital revenues up to the upper payment limit, which could be in jeopardy if revenues were reduced. If there are insufficient revenues to "fully fund" all of the prioritized uses of the Hospital Provider Fee, the Medical Services Board is required to adopt rules for reducing Medicaid eligibility or benefits. These rules have to be approved by the JBC before they could take effect, but if the JBC doesn't like the rules, then the JBC has to propose rules for limiting eligibility or benefits.

Senate Bill 13-200 and the federal Affordable Care Act protect some of the expansion populations from reductions in eligibility or benefits. Senate Bill 13-200 included provisions protecting the Medicaid expansion populations required to receive the ACA's enhanced federal match from reductions due to insufficient hospital provider fee revenues. The ACA included a maintenance of effort requirement for eligibility for children until October 2019. The remaining eligibility criteria and benefits that are financed from the Hospital Provider Fee that could potentially be reduced if there are insufficient revenues would be the disabled buy-in program, services for pregnant adults on CHP+, and continuous eligibility for children.[1]

If the intent were to reduce eligibility or benefits for the disabled buy-in, services for pregnant adults on CHP+, and continuous eligibility for children, then implanting a restriction on the Hospital Provider Fee through the Long Bill would be appropriate. However, if the intent is to reduce the booster payments without reducing Medicaid eligibility or benefits, as proposed by the Governor, then the statutory priority order does not reflect the actual priorities of the General Assembly and should be changed or eliminated.

During debate on the FY 2016-17 budget the JBC received an opinion from Legislative Legal Services, dated December 7, 2015, that reducing Hospital Provider Fee revenues without reducing

[1] The ACA maintenance of effort requirement for children applies to eligibility standards as of the passage of the ACA and so it does not apply to Colorado's continuous eligibility for children, which was implemented after the ACA.

Medicaid eligibility or benefits would require legislation, due to the way the statutes prioritize expenditures from the Hospital Provider Fee when revenues are insufficient. Despite the legal opinion, the JBC implemented a $73.2 million restriction on Hospital Provider Fee revenues through the FY 16-17 Long Bill. The Colorado Hospital Association lobbied against a separate bill to implement the restriction, arguing that the magnitude of the proposed restriction fell within potential interpretations of what it means to "maximize" inpatient and outpatient revenues and "fully fund" all of the prioritized uses of the Hospital Provider Fee. The JBC's decision last year was not challenged, but had there been a successful legal challenge the Department and the JBC potentially would have had to restrict eligibility and benefits. The magnitude of the proposed restriction this year is larger than last year, which might increase the risk of a legal challenge.

**ALTERNATIVE – REPLACE HOSPITAL BOOSTER PAYMENTS WITH A PROVIDER RATE INCREASE**

If legislators want to mitigate the effect on hospitals of the staff recommendation, a possible alternative would be to replace hospital booster payments with a provider rate increase. When the Hospital Provider Fee booster payments were created, they allowed the state to increase reimbursements to hospitals with no cost to the General Fund. Hospitals paid the state a dollar to get two dollars in return for a net benefit of $1. However, in a TABOR refund environment, booster payments are an inefficient way to deliver increased funding to hospitals. This is because the revenue from the Hospital Provider Fee increases the General Fund obligation for a TABOR refund. To give the hospitals a net benefit of $1 costs the General Fund $1 in increased TABOR refunds. It is as if the General Assembly made a direct General Fund payment to the hospitals with no matching federal funds. If the same net benefit of $1 was provided through a rate increase for the hospitals, it would only cost the General Fund $0.50 at the standard federal match rate. However, because some of the populations and treatments provided by the hospitals are eligible for enhanced federal matching funds, the cost to the General Fund would be even less. Based on the mix of populations and treatments that the Department projects hospitals will provide in FY 2017-18, the average General Fund match rate for fee-for-service payments to hospitals is expected to be 27.9 percent.

If the JBC wanted to replace $10 million from the Hospital Provider Fee with a rate increase, it would cost $2.8 million General Fund to hold the hospitals harmless in aggregate, and the General Fund would pay $10 million less in TABOR refunds, resulting in a net savings to the General Fund of $7.2. This example, summarized in the table below, is scalable, so if the JBC wanted to replace the entire $195.0 million reduction to the Hospital Provider Fee that is recommended by the JBC staff with a rate increase to hold hospitals harmless, the net savings to the General Fund would be $140.7 million. This is less than the $195.0 million savings to the General Fund under the JBC staff recommendation, but it is still a considerable savings. If the JBC wanted to achieve the same $195.0 million of General Fund savings recommended by the JBC staff, it could do so by replacing $270.3 million from the Hospital Provider Fee with a provider rate increase.

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|---|---|
| Restrict Hospital Provider Fee (HPF) revenue | ($10,000,000) |
| | |
| Effect on hospitals | |
| Net loss in HPF booster payments | ($10,000,000) |
| Provider rate increase | $10,000,000 |
| Net benefit to hospitals | $0 |
| | |
| Effect on the General Fund | |
| TABOR Refund (not appropriated) | ($10,000,000) |
| GF cost of rate increase | $2,786,965 |
| Net benefit to General Fund | ($7,213,035) |

There are a some limits on how much General Fund savings the JBC could achieve by replacing Hospital Provider Fee booster payments with a provider rate increase. First, the cut to the Hospital Provider Fee cannot exceed the booster payments. The projected Hospital Provider Fee expenditure in FY 2017-18 from the Medical Services Premiums line item for hospital booster payments is $465.2 million. Potentially, the General Assembly could also replace booster payments from the Safety Net Provider Payments line item with rate increases, but that would require a reimagining of the Colorado Indigent Care Program. Second, the cut to the Hospital Provider Fee cannot exceed the TABOR refund, because the General Fund savings from this strategy is dependent on reducing the General Fund obligation for a TABOR refund. The March revenue forecast will provide a new estimate of the TABOR refund. The actual TABOR refund will be dependent on actual revenues. In December the Legislative Council Staff projected a TABOR refund obligation of $279.4 million and the Office of State Planning and Budgeting projected a TABOR refund obligation of $247.7 million.

While replacing Hospital Provider Fee revenues with a rate increase could hold hospitals harmless in aggregate, it would most likely result in a reallocation of resources between hospitals. The larger the change in financing the greater the distortion will be from the status quo distribution by hospital. The Department could potentially make adjustments to the distribution formula for any remaining Hospital Provider Fee booster payments to minimize the change in funding by hospital, if this was a policy goal, but it is unlikely that a new distribution formula plus a rate increase could exactly duplicate the current allocation of funds by hospital.

Reducing Hospital Provider Fee revenues and increasing provider rates would require federal approval from the Centers for Medicare and Medicaid Services (CMS). The size of the change in financing might influence the level of CMS scrutiny and the time required to receive approval. The Department has accounted for the time required to get CMS approval for a change in the Hospital Provider Fee revenues in the request. A reduction in revenues may not be evenly distributed through the state fiscal year, but the Department believes a reduction in revenues to a specific dollar amount identified by the General Assembly is achievable within the fiscal year. Similarly, a rate increase might not be approved by CMS by July 1, but upon CMS approval it could be implemented retroactively to July 1.

The JBC staff is not recommending this alternative in part because it may have unintended consequences. As noted above, replacing the Hospital Provider Fee with a rate increase will likely change the distribution of funding among hospitals and that could have negative consequences for the delivery system, but it is unknown whether and how the Department might change the distribution formula for the remaining booster payments and what the final result would be by

hospital. One factor in the distribution of the Hospital Provider Fee is quality of care, but that is not a consideration in the current fee-for-service rates. Also, if hospital provider rates are increased, then the effect on the budget of future changes in the utilization of hospital services is magnified.

Another consideration is that the Governor's request is for a temporary reduction to the Hospital Provider Fee, while a provider rate increase for the hospitals would be perceived as permanent. The JBC staff is uncomfortable recommending a rate increase for a specific provider, particularly if it is a large increase, that hasn't been through the S.B. 15-228 rate review process or a similar vetting. It could be that increasing rates for a different provider turns out to be more important for the delivery system than backfilling lost revenue to the hospitals from the Hospital Provider Fee. While it may be unrealistic to assume that the budget environment will be significantly better next year such that restoring the Hospital Provider Fee will be easy, there might be more clarity about where Medicaid provider rates are causing the most issues with access and where backfilling lost revenue from the Hospital Provider Fee falls among the Department's priorities.

Another consideration is that the net benefit to hospitals from the Hospital Provider Fee has been significantly greater than originally expected. When the Hospital Provider Fee was created it was not expected that the expansion populations would receive an enhanced federal match pursuant to the ACA. That match for FY 2017-18 is 94.5 percent. The enhanced federal match reduces the amount of Hospital Provider Fee revenue that goes to providers other than hospitals for services to expansion populations and increases the proportion of the Hospital Provider Fee that directly benefits the hospitals. Also, when the Hospital Provider Fee was created the effect of the Medicaid expansion on increasing the federal limits on the Hospital Provider Fee was not fully understood.

The booster payments have not always been in place and during their existence there have been frequent variations in funding levels, including large diversions from the booster payments to offset the need for General Fund as follows:

- $46.3 million in FY 2009-10
- $53.5 million in FY 2010-11
- $50.0 million in FY 2011-12
- $25.0 million in FY 2012-13
- $73.1 million in FY 2016-17

**ALTERNATIVE – DESIGNATE THE HOSPITAL PROVIDER FEE AS AN ENTERPRISE**

In prior years the Governor has proposed that rather than limiting the Hospital Provider Fee revenue, the General Assembly designate the Hospital Provider Fee as part of an enterprise, which would make the revenue exempt from TABOR. The Governor then goes one step further and argues that doing so would not require an adjustment to the TABOR base. Designating the Hospital Provider Fee as an enterprise would remove roughly $870 million in projected revenue attributable to the Hospital Provider Fee from the calculation of whether a TABOR refund is due. This does not mean that there would be $870 million more General Fund available for the budget. The amount of General Fund savings would be dependent on the size of the TABOR refund absent a change in policy.

In addition to saving General Fund that would otherwise be needed for a TABOR refund, designating the Hospital Provider Fee as an enterprise would remove the budget balancing reason to implement the Governor's proposed restriction on Hospital Provider Fee revenues.

There would be some secondary effects from designating the Hospital Provider Fee as an enterprise. First, the conservation easement tax credit would remain non-refundable. Pursuant to Section 39-22-522 (5) (b), C.R.S., a portion of the tax credit becomes refundable if a TABOR surplus is due. Second, the General Assembly would be allowed to eliminate tax expenditures without prior voter approval in FY 2017-18, if it wanted, which could increase General Fund revenues. The conclusion that limiting tax expenditures without prior voter approval is allowable when it doesn't cause a TABOR refund is based on the Colorado Supreme Court's decision in Mesa County Bd. of County Comm'rs v. State.

The two main downsides to designating the Hospital Provider Fee as an enterprise are that: (1) it may not be constitutional; and (2) it eliminates projected TABOR refunds taxpayers could otherwise expect to receive. There could be legal costs if a designation of the Hospital Provider Fee as an enterprise is challenged. If it is found unconstitutional, the state would owe a refund for money retained illegally through the policy for up to four full fiscal years prior to the date a suit is filed, plus 10 percent annual simple interest.

The dollar risk of designating the Hospital Provider Fee as an enterprise and subsequently receiving a court determination that it is unconstitutional is dependent on when a law suit is filed and resolved and on how much revenue is retained. It is important to note that the Governor's budget, including budget amendments, was balanced in January assuming $195 million in savings from restricting Hospital Provider Fee revenues. So, when looking at what designating the Hospital Provider Fee as an enterprise would save compared to the Governor's request, the total savings from the enterprise designation needs to be reduced by the $195 million that the Governor was already counting on achieving through a different policy action.

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# LEGAL MEMORANDUM

TO: The Joint Budget Committee

FROM: Office of Legislative Legal Services

DATE: December 7, 2015

SUBJECT: Reduction in hospital provider fee revenue[1]

## Legal Questions and Short Answers

1. Governor Hickenlooper's proposed budget for fiscal year 2016-17 (budget) proposes a $100 million dollar decrease in hospital provider fee (HPF) revenue. Would decreasing HPF revenue by $100 million dollars require additional legislation?

**Short Answer:** No. Under current law, the Medical Services Board (state board) in the Department of Health Care Policy and Financing (department) is required to set the amount of the HPF approximately equal to the General Assembly's appropriation specified for the fee. If the General Assembly reduces the HPF cash fund appropriation in the annual general appropriation act, the state board should reduce the HPF, thereby reducing HPF revenue to match the appropriation.

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[1] This legal memorandum results from a request made to the Office of Legislative Legal Services (OLLS), a staff agency of the General Assembly. OLLS legal memoranda do not represent an official legal position of the General Assembly or the State of Colorado and do not bind the members of the General Assembly. They are intended for use in the legislative process and as information to assist the members in the performance of their legislative duties.

2. Governor Hickenlooper's budget proposes reducing HPF revenue by $100 million dollars without any reduction in medical benefits or eligibility. Under current law, could HPF revenues be reduced by $100 million dollars without any reduction in medical benefits or eligibility?

> **Short Answer:** No. If HPF revenues and federal matching funds are insufficient to fully fund all of the purposes for the HPF, the HPF statute requires HPF revenue to be used first to fully fund hospital reimbursement and incentive payments and certain administrative expenses relating to the fee, with any remaining HPF revenue used to fund the expansion of medical benefits or eligibility. Without legislation amending the HPF statute, the state board is required to adopt rules, to be approved by the Joint Budget Committee, that reduce medical benefits or eligibility to match available HPF revenue.

3. Any state board rules that reduce medical benefits or eligibility pursuant to the requirement in the HPF statute must comply with the requirement in the "State Administrative Procedure Act"[2] that agency rules not conflict with other provisions of law. Would state board rules adopted pursuant to the HPF statute that reduce medical benefits or eligibility conflict with other provisions of law?

> **Short Answer:** Partly, yes. State and federal law enacted subsequent to the enactment of the HPF statute limits, in part, the state board's authority to reduce medical benefits or eligibility pursuant to the HPF statute.

4. State TABOR[3] revenue for FY 2016-17 is forecast to exceed the state spending limit by over $250 million.[4] Governor Hickenlooper's budget proposes reducing HPF revenue by $100 million, which would reduce the forecasted TABOR refund by $100 million and make $100 million of additional general fund money available for expenditure. By increasing available general fund money, does the proposal convert the HPF from a fee into a tax and trigger TABOR voter approval requirements?

> **Short Answer:** No. Based on relevant Colorado Supreme Court precedents, the HPF currently satisfies all legal requirements for classification under TABOR as a fee rather than a tax. Reducing the amount of HPF revenue collected as

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[2] Section 24-4-101, C.R.S., et seq.

[3] *The Taxpayer's Bill of Rights,* Colo. Const., art X, sec. 20.

[4] Colorado Legislative Council Staff Economics Section, *Focus Colorado: Economic and Revenue Forecast,* September 21, 2015.

proposed does not convert the HPF from a fee to a tax and does not trigger TABOR voter approval requirements.

# Discussion

**1. The HPF statute requires the state board to establish the HPF approximately equal to the General Assembly's appropriations specified for the fee.**

The state board has the authority to establish the amount of the HPF and the rules governing the fee.[5] However, the state board's authority to establish the amount of the HPF is tied to the General Assembly's power to appropriate HPF cash funds. All money in the HPF cash fund is "subject to federal matching as authorized under federal law and subject to annual appropriation by the general assembly . . . " for the purposes set forth in the HPF statute.[6] Section 25.5-4-402.3 (3) (b), C.R.S., reads in part:

> **25.5-4-402.3. Providers - hospital - provider fees - legislative declaration - federal waiver - fund created - rules - advisory board - repeal.** (3) (b) The provider fees shall be assessed pursuant to rules adopted by the state board, pursuant to section 24-4-103, C.R.S. **The amount of the fee shall be established by rule of the state board** but shall not exceed the federal limit for such fees. **In establishing the amount of the fee** and in promulgating the rules governing the fee, **the state board shall:**
>
> (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. (**emphasis added**)

Pursuant to section 25.5-4-402.3 (3) (b), C.R.S., if the General Assembly were to reduce its appropriation of HPF cash funds in the annual general appropriations act from the amount appropriated in the previous year, the state board would be required to adopt rules for the assessment of the fee that result in HPF revenue that approximates the General Assembly's reduced appropriation. Therefore, without additional legislation, a $100 million dollar reduction in the General Assembly's appropriation of HPF cash funds should result in a reduction in the HPF and the collection of approximately $100 million dollars less in HPF revenue.

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[5] Section 25.5-4-402.3 (3) (b), C.R.S.

[6] Section 25.5-4-402.3 (4) (b), C.R.S.

## 2. The HPF statute contemplates that HPF revenue may be insufficient to fully fund all of the statutory purposes for the HPF.

### 2.1. The HPF statute prioritizes the use of HPF revenue when revenue is insufficient to fully fund all of the statutory purposes for the HPF.

The statutory purposes for the HPF are set forth in section 25.5-4-402.3 (4) (b), C.R.S. That section reads in part:[7]

> **25.5-4-402.3. Providers - hospital - provider fees - legislative declaration - federal waiver - fund created - rules - advisory board - repeal.** (4) (b) **All moneys in the fund shall be subject to** federal matching as authorized under federal law and subject to **annual appropriation by the general assembly for the following purposes:**
>
> (I) To **maximize** the **inpatient and outpatient hospital reimbursements to up to the upper payment limits** as defined in 42 CFR 447.272 and 42 CFR 447.321;
>
> (II) To **increase hospital reimbursements under the Colorado indigent care program** to up to one hundred percent of the hospital's costs of providing medical care under the program;
>
> (III) To **pay the quality incentive payments** provided in section 25.5-4-402 (3);
>
> (IV) **Subject to available revenue from the provider fee and federal matching funds,** to **expand eligibility for public medical assistance by:**
>
> (A) Increasing the eligibility level for **parents and caretaker relatives** of children who are eligible for medical assistance, pursuant to section 25.5-5-201 (1) (m), from sixty-one percent to **one hundred thirty-three percent** of the federal poverty line;
>
> (B) Increasing the eligibility level for **children and pregnant women** under the **children's basic health plan** to up to **two hundred fifty percent** of the federal poverty line;
>
> (C) Providing eligibility under the state medical assistance program for a **childless adult** or an adult without a dependent child in the home, pursuant to section 25.5-5-201 (1) (p), who earns up to **one hundred thirty-three percent** of the federal poverty line;
>
> (D) Providing **a buy-in program** in the state medical assistance program for **disabled adults and children** whose families have income of up to **four hundred fifty percent** of the federal poverty line;
>
> (V) To provide **continuous eligibility for twelve months for children** enrolled in the state medical assistance program;

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[7] Details of the state department's actual administrative costs and repealed provisions have been omitted.

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

[. . .]

(VII) To offset the loss of any federal matching funds due to a decrease in the certification of the public expenditure process for outpatient hospital services for medical services premiums that were in effect as of July 1, 2008. (**emphasis added**)

While HPF revenue may be used for all of the enumerated purposes, in the event revenue is insufficient to fully fund all of the purposes, the HPF statute prioritizes the use of the existing HPF revenue. Section 25.5-4-402.3 (5) (b), C.R.S., reads in part:

**25.5-4-402.3. Providers - hospital - provider fees - legislative declaration - federal waiver - fund created - rules - advisory board - repeal.** (5) (b) If the revenue from the 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 revenue from the provider fee and federal matching funds **before any eligibility expansion is funded;** and (**emphasis added**)

Pursuant to section 25.5-4-402.3 (5) (b) (II), C.R.S., in the event there is insufficient revenue to fully fund all of the enumerated purposes, the hospital reimbursements and payments described in subparagraphs (4) (b) (I) to (4) (b) (III) must be "**fully funded using revenue from the provider fee** . . . **before any eligibility expansion is funded**". This includes maximizing the inpatient and outpatient hospital provider reimbursements up to the upper payment limits, increasing hospital reimbursements under the Colorado Indigent Care Program up to one hundred percent, and making quality incentive payments. In addition, fully funding the department's administrative costs and offsetting the loss of federal matching funds in certain circumstances pursuant to subparagraphs (4) (b) (VI) and (4) (b) (VII) take priority over funding any expanded medical benefits or eligibility.

Statutory language further supports the elevation of subparagraphs (4) (b) (I) to (4) (b) (III), (4) (b) (VI), and (4) (b) (VII) over the expansion of medical benefits or eligibility. Subparagraph (4) (b) (IV), which lists expansions in medical benefits and eligibility criteria, begins with the introductory phrase "[s]ubject to available revenue from the provider fee". No such limiting language introduces the other statutory purposes for the HPF enumerated in paragraph (4) (b). Therefore, HPF revenue must first be used to accomplish the goals described in subparagraphs (4) (b) (I) to (4) (b) (III), (4) (b)

(VI), and (4) (b) (VII) before any remaining "available" revenue is used for expanded medical benefits or eligibility pursuant to subparagraph (4) (b) (IV).

Further, while the phrase "to maximize the inpatient and outpatient hospital reimbursements to up to the upper payment limit" in subparagraph (4) (b) (I) is not defined in statute, the language of section 25.5-4-402.3, C.R.S., taken as a whole, provides some basis for discerning legislative intent. Given the entire statutory scheme creating the HPF and the numerous references to "fully" funding hospital reimbursements before "any" revenue is used to fund the expansion of medical benefits or eligibility, the phrase "to maximize the inpatient and outpatient hospital reimbursements to up to the upper payment limit" in subparagraph (4) (b) (I) may fairly be interpreted to mean fully funding hospital reimbursements by increasing reimbursements to the highest practicable level allowed by federal guidelines governing the upper payment limit and by the General Assembly's appropriation.

### 2.2. When revenue is insufficient to fully fund all of the statutory purposes for the HPF, the state board must adopt rules reducing medical benefits or eligibility to the level of available HPF revenue.

The HPF statute specifically contemplates that HPF revenue may be insufficient to fully fund all of the statute's purposes. If medical benefits or eligibility has already been expanded pursuant to subparagraph (4) (b) (IV), in the event HPF revenue is insufficient, the state board, with the approval of the Joint Budget Committee, must reduce medical benefits or eligibility to the level necessary to match available HPF revenue. Section 25.5-4-402.3 (5) (b) (III), C.R.S., reads in part:

> **25.5-4-402.3. Providers - hospital - provider fees - legislative declaration - federal waiver - fund created - rules - advisory board - repeal.** (5) (b) If the revenue from the provider fee is insufficient to fully fund all of the purposes described in paragraph (b) of subsection (4) of this section:
>
> (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 that **the revenue available from the provider fee** and the federal matching funds **will not be sufficient to pay for all or part of the expanded eligibility,** the advisory board **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, 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 state department, 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 revenue from the 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. (**emphasis added**)

Therefore, in the event that HPF revenue is insufficient to fully fund all of the statute's enumerated purposes, HPF revenue must be used first to fully fund hospital reimbursements and incentive payments and administrative costs and, subject to the limitations discussed in section 3 of this memo, the state board must adopt rules reducing medical benefits or eligibility to match the remaining HPF revenue.

### 3. Without statutory changes or other state action, the state board's ability to adopt rules reducing medical benefits and eligibility in response to insufficient HPF revenue is limited, in part, by other state and federal law.

Except as provided in section 25.5-4-402.3 (5) (b) (III), C.R.S., relating to delayed filing of the rules, the state board's rules reducing medical benefits or eligibility in response to reduced HPF revenue must comply with the "State Administrative Procedure Act".[8] Section 24-4-103 (4) (b), C.R.S., prohibits the adoption of rules that conflict with other provisions of law.

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[8] Section 24-4-101, C.R.S., et seq.

Subsequent to the enactment of the HPF statute in 2009, Congress passed the Affordable Care Act[9] (ACA) in 2010. The ACA made numerous changes to the Medicaid program, including increasing income eligibility levels for existing eligibility groups and expanding eligibility to childless adults. Colorado elected to participate in the ACA's expanded Medicaid eligibility for childless adults. In 2013, the General Assembly enacted S.B. 13-200, which amended section 25.5-5-201, C.R.S, relating to optional Medicaid groups. In S.B. 13-200, the General Assembly removed language in section 25.5-5-201 (1) (m) and (1) (p), C.R.S., that specifically permitted the state board to use the mechanism set forth in the HPF statute to reduce income and eligibility levels for parents and caretaker relatives and childless adults in the event HPF revenue is insufficient to fully fund all of the purposes for the HPF. Further, until 2019, the ACA prohibits Colorado from reducing income eligibility for children under the Medicaid program and the Children's Basic Health Plan.[10]

With respect to the expanded medical benefits or eligibility that may be reduced by rule of the state board, state and federal law do not appear to limit the ability of the state board to reduce certain medical benefits or eligibility described in section 25.5-4-402.3 (4) (b) (IV), C.R.S. These medical benefits or eligibility include the Medicaid buy-in program for adults and children with disabilities, continuous eligibility for children enrolled in the Medicaid program, and income eligibility for pregnant women under the Children's Basic Health Plan. However, eliminating these programs may not result in a reduction of $100 million dollars in services.

Therefore, if HPF revenue is reduced by $100 million dollars as proposed in the Governor's budget, absent changes to state law and state action relating to Colorado's Medicaid program and the Children's Basic Health Plan, state and federal law enacted subsequent to the enactment of the HPF statute limits some, but not all, of the state board's authority to adopt rules reducing medical benefits and eligibility in response to a reduction in HPF revenue.

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[9] Patient Protection and Affordable Care Act, 42 U.S.C. sec 18001 et seq.

[10] Section 25.5-8-101, C.R.S., et seq.

## 4. The HPF currently satisfies all legal requirements for classification under TABOR as a fee rather than a tax, and reducing the amount of HPF revenue collected as proposed does not convert it into a fee or require voter approval under TABOR.

### 4.1. As currently imposed, the HPF is a fee, not a tax, for purposes of TABOR.

Section (4) (a) of TABOR requires "voter approval in advance" for "any new tax, tax rate increase, . . . extension of an expiring tax, or . . . tax policy change directly causing a net tax revenue gain," but does not require such voter approval for increases in other government-imposed charges, such as fees, fines, and penalties, that do not increase tax revenue. TABOR does not define the term "tax", but the Office of Legislative Legal Services has developed a sequential series of tests, based upon Colorado judicial decisions, for the purpose of determining whether a charge is a "tax" for purposes of TABOR. Applying the tests in order, to the extent necessary, to the HPF establishes that the HPF is a fee, not a tax.

The first test is whether the charge being examined is imposed by legislative authority to raise money for a public purpose. If so, it may be a tax. Because the HPF is imposed pursuant to statute and raises money that is used to fund state medical assistance program and Colorado indigent care program services, it satisfies the first test.

The second test requires a determination as to whether the HPF is a type of governmental charge that is not a tax, such as a fee, fine, or penalty. Colorado Supreme Court decisions indicate that while a tax is imposed for the purpose of raising revenue to defray general expenses of government,[11] a fee is a charge that: (1) Is imposed to defray the cost of a particular governmental service; (2) Is imposed in an amount that is reasonably related to the overall cost of the service, even though mathematical exactitude is not required; and (3) At the time it is first imposed, is not made primarily for the purpose of raising revenue for general public purposes.[12]

The General Assembly originally imposed and has continued to impose the HPF not to defray general expenses of government, but instead for the limited purpose of "obtaining federal financial participation under the state medical assistance program . . . and the Colorado indigent care program . . ." so that it can increase reimbursement to

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[11] For example, the vast majority of revenue generated by the state income tax and the state sales and use taxes is credited to the general fund and accounts for over 96% of general fund revenue.

[12] *See Tabor Foundation v. Colorado Bridge Enterprise,* 2014 COA 106, PP 21-44; *Barber v. Ritter,* 196 P.3d 238, 248-49 (Colo. 2008); *Bloom v. City of Fort Collins,* 784 P.2d 304, 308 (Colo. 1989).

hospitals for services provided under the state medical assistance program and the Colorado indigent care program, cover more people with public medical assistance, and defray its own administrative costs of implementing and administering the HPF program.[13] In addition, the requirement that HPF-funded services be limited or prioritized, as detailed in section 2 of this memorandum, when HPF revenue is insufficient to fund hospital reimbursements to the upper payment limit supports the conclusion that the HPF is imposed at a level that is reasonably related to the cost of the HPF program. Because the HPF therefore meets the requirements of a fee, it is not a tax for purposes of TABOR.

### 4.2. Reducing HPF revenue by $100 million would not convert the HPF from a fee into a tax and would not trigger TABOR voter approval requirements.

HPF revenue is included in state fiscal year spending (TABOR revenue) and counts against the state fiscal year spending limit (limit). For a fiscal year in which TABOR revenue exceeds the limit, reducing HPF revenue reduces TABOR revenue and thereby also reduces the amount of the TABOR refund, which is paid from the general fund, on a dollar for dollar basis until TABOR revenue no longer exceeds the limit. Because such a reduction in the amount that must be refunded from the general fund makes more general fund money available for expenditure, it has been suggested that reducing HPF revenue converts the HPF from a fee into a tax and requires voter approval. But Colorado Supreme Court precedent establishes that such a conversion does not occur.

Between 2001 and 2004, in order to increase the amount of general fund money available to fund various state programs and services during and following an economic downturn, the general assembly enacted legislation that transferred a total amount of over $442 million from various cash funds to the general fund. The money transferred from the cash funds had originally been generated by various state-imposed fees, surcharges, and special assessments, and had, like HPF revenue, been counted as TABOR revenue when first received by the state.

In a lawsuit filed against the state, fee and surcharge paying plaintiffs alleged that "the transfers from the special funds to the general fund represented a tax policy change directly causing a net tax revenue gain, a new tax, or a tax rate increase, without voter approval in violation of [TABOR] because the transferred monies, which [plaintiffs alleged] became general tax dollars as a result of the transfer, would be expended to defray general governmental expenses unrelated to the respective purposes for which

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[13] Section 25.5-5-402.3 (3) (a), C.R.S.

the cash funds were created.[14] The Colorado Supreme Court rejected the claim, stating that "the primary purpose for which the legislature originally imposes a charge is the dispositive criteria in determining whether that charge is a fee or a tax," that "[i]t is undisputed here that, while the monies resided in the special cash funds, they were fees," that "[t]he fact that the fees were eventually transferred to the general fund does not alter their essential character as fees because the transfer does not change the fact that the primary object for which they were collected was not to defray the general cost of government," and that "[a]t most, the transfer of fees to a general fund where, as here, the statutes authorizing assessment of those fees do not contemplate the generation of revenue for general use, incidentally makes funds available to defray the general cost of government," and "does not transform a fee into a tax."[15] Here, the HPF as currently imposed satisfies the tests for classification as a fee for TABOR purposes, and the relevant judicial precedent establishes that even a direct transfer of HPF fees to the general fund would not convert the HPF into a tax. Accordingly, the proposed reduction of HPF revenue, which does not transfer any HPF revenue or cause HPF revenue to be used for any purpose for which it is not already used, clearly would not effect such a conversion and, since TABOR voter approval requirements do not apply to fees, would not require voter approval.

## Conclusion

Under current law, the General Assembly may trigger a reduction in the HPF and the resulting revenue by reducing HPF cash fund appropriations by $100 million dollars. If the resulting HPF revenue is insufficient to fully fund all of the purposes for the HPF, the existing HPF revenue would be allocated pursuant to the prioritization in the HPF statute. Under current law, HPF revenue and the federal matching funds must be used first to fully fund hospital reimbursements and incentive payments and the department's administrative costs, before any remaining available revenue is used to fund the expansion of medical benefits or eligibility. The state board is directed to adopt rules reducing medical benefits or eligibility to match available HPF revenue. However, absent changes to state law and state action relating to Colorado's Medicaid program and the Children's Basic Health Plan, state and federal law enacted subsequent to the enactment of the HPF statute limits some, but not all, of the state board's authority to adopt rules reducing medical benefits and eligibility in response to

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[14] *Barber,* 196 P.3d at 244 (internal quotations omitted).

[15] *Id.,* at 249-50 and 249 n.13 (internal citations omitted).

insufficient HPF revenue. Finally, the General Assembly may act to reduce HPF revenue without voter approval.

| Hospital | County | Rural Hospital | Critical Access Hospital | $669.3M HPF Budget Limit | | | $864.4M HPF | | | Net Reimbursement Change |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | SFY 2017-18 Provider Fee | SFY 2017-18 Supplemental Payment | Net Reimbursement | SFY 2017-18 Provider Fee | SFY 2017-18 Supplemental Payment | Net Reimbursement | |
| | | | | A | B | C = B-A | D | E | F = E-D | = C-F |
| Children's Hospital Colorado | Adams | | | $ 23,059,383 | $ 28,972,854 | $ 5,913,471 | $ 29,782,222 | $ 42,687,141 | $ 12,904,920 | $ (6,991,449) |
| HealthOne North Suburban Medical Center | Adams | | | $ 14,841,489 | $ 26,064,411 | $ 11,222,922 | $ 19,168,445 | $ 38,401,988 | $ 19,233,543 | $ (8,010,621) |
| HealthOne Spalding Rehabilitation Hospital | Adams | | | $ - | $ (10,950) | $ (10,950) | $ - | $ - | $ - | $ (10,950) |
| Kindred Hospital Aurora | Adams | | | $ - | $ 296,904 | $ 296,904 | $ - | $ 363,852 | $ 363,852 | $ (66,948) |
| Platte Valley Medical Center | Adams | | | $ 5,185,530 | $ 11,366,862 | $ 6,181,332 | $ 6,697,343 | $ 16,747,361 | $ 10,050,018 | $ (3,868,686) |
| University of Colorado Hospital | Adams | | | $ 52,274,571 | $ 58,662,075 | $ 6,387,504 | $ 67,514,940 | $ 86,429,741 | $ 18,914,802 | $ (12,527,298) |
| Vibra Long Term Acute Care Hospital | Adams | | | $ - | $ (19,725) | $ (19,725) | $ - | $ - | $ - | $ (19,725) |
| San Luis Valley Regional Medical Center | Alamosa | ✓ | | $ 2,331,645 | $ 5,039,661 | $ 2,708,016 | $ 3,011,424 | $ 7,425,182 | $ 4,413,759 | $ (1,705,743) |
| Centura Health - Littleton Adventist Hospital | Arapahoe | | | $ 16,285,854 | $ 9,652,278 | $ (6,633,576) | $ 21,033,907 | $ 14,221,179 | $ (6,812,727) | $ 179,151 |
| Craig Hospital | Arapahoe | | | $ - | $ (59,460) | $ (59,460) | $ - | $ - | $ - | $ (59,460) |
| HealthOne Medical Center of Aurora | Arapahoe | | | $ 26,649,360 | $ 20,695,914 | $ (5,953,446) | $ 34,418,837 | $ 30,492,315 | $ (3,926,522) | $ (2,026,924) |
| HealthOne Swedish Medical Center | Arapahoe | | | $ 38,737,929 | $ 40,481,319 | $ 1,743,390 | $ 50,031,763 | $ 59,643,133 | $ 9,611,370 | $ (7,867,980) |
| HealthSouth Rehabilitation Hospital - Denver | Arapahoe | | | $ - | $ 341,961 | $ 341,961 | $ - | $ 430,236 | $ 430,236 | $ (88,275) |
| Pagosa Mountain Hospital | Archuleta | ✓ | ✓ | $ 472,212 | $ 1,589,136 | $ 1,116,924 | $ 609,883 | $ 2,341,353 | $ 1,731,470 | $ (614,546) |
| Southeast Colorado Hospital | Baca | ✓ | ✓ | $ 212,766 | $ 912,186 | $ 699,420 | $ 274,797 | $ 1,343,969 | $ 1,069,172 | $ (369,752) |
| Boulder Community Hospital | Boulder | | | $ 14,756,817 | $ 12,447,027 | $ (2,309,790) | $ 19,059,087 | $ 18,338,822 | $ (720,266) | $ (1,589,524) |
| Centennial Peaks Hospital | Boulder | | | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Centura Health - Avista Adventist Hospital | Boulder | | | $ 5,522,835 | $ 7,391,628 | $ 1,868,793 | $ 7,132,988 | $ 10,890,452 | $ 3,757,464 | $ (1,888,671) |
| Centura Health - Longmont United Hospital | Boulder | | | $ 10,616,175 | $ 12,553,413 | $ 1,937,238 | $ 13,711,263 | $ 18,495,565 | $ 4,784,302 | $ (2,847,064) |
| Good Samaritan Medical Center | Boulder | | | $ 14,712,456 | $ 7,762,491 | $ (6,949,965) | $ 19,001,793 | $ 11,436,863 | $ (7,564,931) | $ 614,966 |
| Centura Health - Saint Anthony North Hospital | Broomfield | | | $ 10,596,612 | $ 12,946,650 | $ 2,350,038 | $ 13,685,997 | $ 19,074,941 | $ 5,388,944 | $ (3,038,906) |
| Heart of the Rockies Regional Medical Center | Chaffee | ✓ | ✓ | $ 1,232,676 | $ 3,705,321 | $ 2,472,645 | $ 1,592,056 | $ 5,459,233 | $ 3,867,177 | $ (1,394,532) |
| Keefe Memorial Hospital | Cheyenne | ✓ | | $ 88,872 | $ 489,498 | $ 400,626 | $ 114,782 | $ 721,202 | $ 606,420 | $ (205,794) |
| Conejos County Hospital | Conejos | ✓ | ✓ | $ 117,402 | $ 531,021 | $ 413,619 | $ 151,630 | $ 782,380 | $ 630,750 | $ (217,131) |
| Delta County Memorial Hospital | Delta | ✓ | | $ 3,117,420 | $ 3,499,470 | $ 382,050 | $ 4,026,287 | $ 5,155,943 | $ 1,129,656 | $ (747,606) |
| Centura Health - Porter Adventist Hospital | Denver | | | $ 16,861,284 | $ 10,945,947 | $ (5,915,337) | $ 21,777,100 | $ 16,127,206 | $ (5,649,894) | $ (265,443) |
| Colorado Acute Long Term Hospital | Denver | | | $ - | $ (5,673) | $ (5,673) | $ - | $ - | $ - | $ (5,673) |
| Colorado Mental Health Institute-Ft Logan | Denver | | | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Denver Health Medical Center | Denver | | | $ 23,363,463 | $ 41,581,098 | $ 18,217,635 | $ 30,174,954 | $ 61,263,492 | $ 31,088,537 | $ (12,870,902) |
| Eating Recovery Center | Denver | | | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| HealthOne Presbyterian/St. Luke's Medical Center | Denver | | | $ 25,987,617 | $ 37,393,962 | $ 11,406,345 | $ 33,564,166 | $ 55,094,377 | $ 21,530,210 | $ (10,123,865) |
| HealthOne Rose Medical Center | Denver | | | $ 19,024,830 | $ 19,795,680 | $ 770,850 | $ 24,571,416 | $ 29,165,956 | $ 4,594,540 | $ (3,823,690) |
| Kindred Hospital | Denver | | | $ - | $ (4,089) | $ (4,089) | $ - | $ - | $ - | $ (4,089) |
| National Jewish Health | Denver | | | $ 1,637,130 | $ 5,773,419 | $ 4,136,289 | $ 2,114,426 | $ 8,506,264 | $ 6,391,838 | $ (2,255,549) |

| Hospital | County | Rural Hospital | Critical Access Hospital | $669.3M HPF Budget Limit | | | $864.4M HPF | | | Net Reimbursement Change |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | SFY 2017-18 Provider Fee | SFY 2017-18 Supplemental Payment | Net Reimbursement | SFY 2017-18 Provider Fee | SFY 2017-18 Supplemental Payment | Net Reimbursement | |
| | | | | A | B | C = B-A | D | E | F = E-D | = C-F |
| Saint Joseph Hospital | Denver | | | $ 22,410,306 | $ 38,385,684 | $ 15,975,378 | $ 28,943,910 | $ 56,555,530 | $ 27,611,620 | $ (11,636,242) |
| Select Specialty Hospital - Denver | Denver | | | $ - | $ 17,070 | $ 17,070 | $ - | $ 25,150 | $ 25,150 | $ (8,080) |
| Centura Health - Castle Rock Adventist Hospital | Douglas | | | $ 1,921,065 | $ 2,392,539 | $ 471,474 | $ 2,481,141 | $ 3,525,046 | $ 1,043,905 | $ (572,431) |
| Centura Health - Parker Adventist Hospital | Douglas | | | $ 10,673,988 | $ 6,450,255 | $ (4,223,733) | $ 13,785,932 | $ 9,503,480 | $ (4,282,451) | $ 58,718 |
| HealthOne Sky Ridge Medical Center | Douglas | | | $ 17,133,714 | $ 5,216,196 | $ (11,917,518) | $ 22,128,956 | $ 7,685,280 | $ (14,443,676) | $ 2,526,158 |
| Highlands Behavioral Health System | Douglas | | | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Vail Valley Medical Center | Eagle | ✓ | | $ 3,007,245 | $ 4,246,425 | $ 1,239,180 | $ 3,883,991 | $ 6,256,468 | $ 2,372,477 | $ (1,133,297) |
| Cedar Springs Behavior Health System | El Paso | | | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Centura Health - Penrose -St. Francis Health Services | El Paso | | | $ 35,919,096 | $ 41,022,120 | $ 5,103,024 | $ 46,391,114 | $ 60,439,922 | $ 14,048,807 | $ (8,945,783) |
| HealthSouth Rehabilitation Hospital - Colorado Springs | El Paso | | | $ - | $ 175,899 | $ 175,899 | $ - | $ 259,161 | $ 259,161 | $ (83,262) |
| Kindred Hospital Colorado Springs | El Paso | | | $ - | $ 11,118 | $ 11,118 | $ - | $ 16,381 | $ 16,381 | $ (5,263) |
| Memorial Hospital | El Paso | | | $ 24,614,289 | $ 31,898,760 | $ 7,284,471 | $ 31,790,452 | $ 46,998,023 | $ 15,207,571 | $ (7,923,100) |
| Peak View Behavioral Health | El Paso | | | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Centura Health - St. Thomas More Hospital | Fremont | ✓ | | $ 1,653,378 | $ 4,533,495 | $ 2,880,117 | $ 2,135,411 | $ 6,679,423 | $ 4,544,011 | $ (1,663,894) |
| Grand River Medical Center | Garfield | ✓ | ✓ | $ 952,491 | $ 3,057,345 | $ 2,104,854 | $ 1,230,185 | $ 4,504,538 | $ 3,274,353 | $ (1,169,499) |
| Valley View Hospital | Garfield | ✓ | | $ 5,099,301 | $ 11,139,639 | $ 6,040,338 | $ 6,585,975 | $ 16,412,582 | $ 9,826,607 | $ (3,786,269) |
| Kremmling Memorial Hospital | Grand | ✓ | ✓ | $ 301,140 | $ 1,811,073 | $ 1,509,933 | $ 388,936 | $ 2,668,344 | $ 2,279,408 | $ (769,475) |
| Gunnison Valley Hospital | Gunnison | ✓ | ✓ | $ 643,719 | $ 1,971,801 | $ 1,328,082 | $ 831,392 | $ 2,905,152 | $ 2,073,760 | $ (745,678) |
| Spanish Peaks Regional Health Center | Huerfano | ✓ | ✓ | $ 224,028 | $ 876,561 | $ 652,533 | $ 289,342 | $ 1,291,481 | $ 1,002,139 | $ (349,606) |
| Centura Health - Ortho Colorado | Jefferson | | | $ 1,186,926 | $ - | $ (1,186,926) | $ 1,532,968 | $ - | $ (1,532,968) | $ 346,042 |
| Centura Health - Saint Anthony Central Hospital | Jefferson | | | $ 21,161,205 | $ 20,829,753 | $ (331,452) | $ 27,330,640 | $ 30,689,507 | $ 3,358,867 | $ (3,690,319) |
| Lutheran Medical Center | Jefferson | | | $ 23,222,628 | $ 17,643,096 | $ (5,579,532) | $ 29,993,060 | $ 25,994,447 | $ (3,998,612) | $ (1,580,920) |
| SCL Health Community Hospital - Westminster | Jefferson | | | $ 369,192 | $ 880,740 | $ 511,548 | $ 476,828 | $ 1,297,638 | $ 820,810 | $ (309,262) |
| UCHealth Broomfield Hospital | Jefferson | | | $ 4,122,801 | $ 4,387,674 | $ 264,873 | $ 5,324,781 | $ 6,464,577 | $ 1,139,796 | $ (874,923) |
| Weisbrod Memorial County Hospital | Kiowa | ✓ | ✓ | $ 67,425 | $ 564,804 | $ 497,379 | $ 87,082 | $ 832,154 | $ 745,071 | $ (247,692) |
| Kit Carson County Memorial Hospital | Kit Carson | ✓ | ✓ | $ 323,904 | $ 1,221,303 | $ 897,399 | $ 418,336 | $ 1,799,406 | $ 1,381,070 | $ (483,671) |
| Animas Surgical Hospital | La Plata | ✓ | | $ 913,113 | $ 1,094,826 | $ 181,713 | $ 1,179,326 | $ 1,613,061 | $ 433,735 | $ (252,022) |
| Centura Health - Mercy Medical Center | La Plata | ✓ | | $ 6,504,303 | $ 12,560,604 | $ 6,056,301 | $ 8,400,597 | $ 18,506,160 | $ 10,105,563 | $ (4,049,262) |
| St. Vincent General Hospital District | Lake | ✓ | ✓ | $ 114,387 | $ 931,593 | $ 817,206 | $ 147,736 | $ 1,372,562 | $ 1,224,826 | $ (407,620) |
| Banner Health Fort Collins | Larimer | | | $ 347,952 | $ 6,137,211 | $ 5,789,259 | $ 449,396 | $ 9,042,257 | $ 8,592,861 | $ (2,803,602) |
| Estes Park Medical Center | Larimer | | ✓ | $ 482,520 | $ 1,662,045 | $ 1,179,525 | $ 623,196 | $ 2,448,773 | $ 1,825,577 | $ (646,052) |
| McKee Medical Center | Larimer | | | $ 5,666,397 | $ 11,991,360 | $ 6,324,963 | $ 7,318,404 | $ 17,667,465 | $ 10,349,060 | $ (4,024,097) |
| Medical Center of the Rockies | Larimer | | | $ 19,077,171 | $ 31,055,613 | $ 11,978,442 | $ 24,639,017 | $ 45,755,773 | $ 21,116,756 | $ (9,138,314) |
| Northern Colorado Long Term Acute Care Hospital | Larimer | | | $ - | $ 6,729 | $ 6,729 | $ - | $ 9,914 | $ 9,914 | $ (3,185) |

| Hospital | County | Rural Hospital | Critical Access Hospital | $669.3M HPF Budget Limit | | | $864.4M HPF | | | Net Reimbursement Change |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | SFY 2017-18 Provider Fee | SFY 2017-18 Supplemental Payment | Net Reimbursement | SFY 2017-18 Provider Fee | SFY 2017-18 Supplemental Payment | Net Reimbursement | |
| | | | | A | B | C = B-A | D | E | F = E-D | = C-F |
| Poudre Valley Hospital | Larimer | | | $ 20,588,238 | $ 21,568,584 | $ 980,346 | $ 26,590,628 | $ 31,778,063 | $ 5,187,436 | $ (4,207,090) |
| Mount San Rafael Hospital | Las Animas | ✓ | ✓ | $ 921,342 | $ 1,461,336 | $ 539,994 | $ 1,189,954 | $ 2,153,059 | $ 963,104 | $ (423,110) |
| Lincoln Community Hospital and Nursing Home | Lincoln | ✓ | ✓ | $ 211,023 | $ 599,931 | $ 388,908 | $ 272,546 | $ 883,908 | $ 611,362 | $ (222,454) |
| Sterling Regional Medical Center | Logan | ✓ | | $ 1,120,545 | $ 5,232,900 | $ 4,112,355 | $ 1,447,234 | $ 7,709,891 | $ 6,262,657 | $ (2,150,302) |
| Colorado West Psychiatric Hospital Inc | Mesa | | | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Community Hospital | Mesa | | | $ 3,351,681 | $ 3,793,245 | $ 441,564 | $ 4,328,845 | $ 5,588,776 | $ 1,259,930 | $ (818,366) |
| Family Health West Hospital | Mesa | | ✓ | $ 667,842 | $ 934,302 | $ 266,460 | $ 862,548 | $ 1,376,553 | $ 514,006 | $ (247,546) |
| St. Mary's Hospital and Medical Center | Mesa | | | $ 23,773,752 | $ 28,376,268 | $ 4,602,516 | $ 30,704,861 | $ 41,808,161 | $ 11,103,300 | $ (6,500,784) |
| The Memorial Hospital | Moffat | ✓ | ✓ | $ 747,237 | $ 5,146,077 | $ 4,398,840 | $ 965,090 | $ 7,581,970 | $ 6,616,880 | $ (2,218,040) |
| Southwest Memorial Hospital | Montezuma | ✓ | ✓ | $ 1,063,872 | $ 3,227,079 | $ 2,163,207 | $ 1,374,038 | $ 4,754,615 | $ 3,380,577 | $ (1,217,370) |
| Montrose Memorial Hospital | Montrose | ✓ | | $ 4,823,964 | $ 4,922,262 | $ 98,298 | $ 6,230,365 | $ 7,252,212 | $ 1,021,848 | $ (923,550) |
| Colorado Plains Medical Center | Morgan | ✓ | | $ 3,907,365 | $ 4,627,920 | $ 720,555 | $ 5,046,536 | $ 6,818,544 | $ 1,772,008 | $ (1,051,453) |
| East Morgan County Hospital | Morgan | ✓ | ✓ | $ 485,238 | $ 972,681 | $ 487,443 | $ 626,707 | $ 1,433,099 | $ 806,393 | $ (318,950) |
| Arkansas Valley Regional Medical Center | Otero | ✓ | ✓ | $ 1,911,591 | $ 3,439,638 | $ 1,528,047 | $ 2,468,905 | $ 5,067,789 | $ 2,598,884 | $ (1,070,837) |
| Haxtun Hospital | Phillips | ✓ | ✓ | $ 60,408 | $ 497,826 | $ 437,418 | $ 78,020 | $ 733,472 | $ 655,452 | $ (218,034) |
| Melissa Memorial Hospital | Phillips | ✓ | ✓ | $ 137,325 | $ 593,796 | $ 456,471 | $ 177,361 | $ 874,869 | $ 697,508 | $ (241,037) |
| Aspen Valley Hospital | Pitkin | ✓ | ✓ | $ 1,187,205 | $ 1,692,480 | $ 505,275 | $ 1,533,328 | $ 2,493,615 | $ 960,286 | $ (455,011) |
| Prowers Medical Center | Prowers | ✓ | ✓ | $ 626,079 | $ 2,911,530 | $ 2,285,451 | $ 808,609 | $ 4,289,701 | $ 3,481,092 | $ (1,195,641) |
| Centura Health - St. Mary-Corwin Medical Center | Pueblo | | | $ 12,527,946 | $ 24,606,342 | $ 12,078,396 | $ 16,180,401 | $ 36,253,743 | $ 20,073,342 | $ (7,994,946) |
| Colorado Mental Health Institute-Pueblo | Pueblo | | | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Parkview Medical Center | Pueblo | | | $ 31,180,752 | $ 42,080,304 | $ 10,899,552 | $ 40,271,332 | $ 61,998,997 | $ 21,727,665 | $ (10,828,113) |
| Pioneers Hospital | Rio Blanco | ✓ | ✓ | $ 144,684 | $ 510,993 | $ 366,309 | $ 186,866 | $ 752,871 | $ 566,005 | $ (199,696) |
| Rangely District Hospital | Rio Blanco | ✓ | ✓ | $ 78,609 | $ 972,357 | $ 893,748 | $ 101,527 | $ 1,432,622 | $ 1,331,095 | $ (437,347) |
| Rio Grande Hospital | Rio Grande | ✓ | ✓ | $ 414,882 | $ 1,387,197 | $ 972,315 | $ 535,839 | $ 2,043,826 | $ 1,507,987 | $ (535,672) |
| Yampa Valley Medical Center | Routt | ✓ | | $ 1,900,245 | $ 6,008,205 | $ 4,107,960 | $ 2,454,251 | $ 8,852,186 | $ 6,397,935 | $ (2,289,975) |
| Sedgwick County Memorial Hospital | Sedgwick | ✓ | ✓ | $ 149,565 | $ 474,432 | $ 324,867 | $ 193,170 | $ 699,004 | $ 505,834 | $ (180,967) |
| Centura Health - Saint Anthony Summit Hospital | Summit | ✓ | | $ 1,684,971 | $ 2,496,159 | $ 811,188 | $ 2,176,215 | $ 3,677,715 | $ 1,501,500 | $ (690,312) |
| Pikes Peak Regional Hospital | Teller | ✓ | ✓ | $ 620,643 | $ 1,211,640 | $ 590,997 | $ 801,588 | $ 1,785,169 | $ 983,581 | $ (392,584) |
| North Colorado Medical Center | Weld | | | $ 18,600,579 | $ 7,987,032 | $ (10,613,547) | $ 24,023,477 | $ 11,767,690 | $ (12,255,787) | $ 1,642,240 |
| Northern Colorado Rehabilitation Hospital | Weld | | | $ - | $ 24,546 | $ 24,546 | $ - | $ 36,165 | $ 36,165 | $ (11,619) |
| Wray Community District Hospital | Yuma | ✓ | ✓ | $ 250,785 | $ 805,899 | $ 555,114 | $ 323,900 | $ 1,187,371 | $ 863,471 | $ (308,357) |
| Yuma District Hospital | Yuma | ✓ | ✓ | $ 337,773 | $ 1,075,068 | $ 737,295 | $ 436,249 | $ 1,583,951 | $ 1,147,702 | $ (410,407) |
| | | | | **$ 669,276,153** | **$ 824,603,649** | **$ 155,327,496** | **$ 864,400,000** | **$ 1,214,929,408** | **$ 350,529,408** | **$ (195,201,912)** |

| Hospital | County | Rural Hospital | Critical Access Hospital | $669.3M HPF Budget Limit | | | $864.4M HPF | | | Net Reimbursement Change |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | SFY 2017-18 Provider Fee | SFY 2017-18 Supplemental Payment | Net Reimbursement | SFY 2017-18 Provider Fee | SFY 2017-18 Supplemental Payment | Net Reimbursement | |
| | | | | A | B | C = B-A | D | E | F = E-D | = C-F |
| Rural Hospital | | | | $ 50,162,778 | $ 110,043,168 | $ 59,880,390 | $ 64,787,465 | $ 162,132,051 | $ 97,344,586 | $ (37,464,196) |
| Non Rural Hospitals | | | | $ 619,113,375 | $ 714,560,481 | $ 95,447,106 | $ 799,612,535 | $ 1,052,797,357 | $ 253,184,822 | $ (157,737,716) |
| **Total** | | | | **$ 669,276,153** | **$ 824,603,649** | **$ 155,327,496** | **$ 864,400,000** | **$ 1,214,929,408** | **$ 350,529,408** | **$ (195,201,912)** |

**Assumptions:**

FMAP for SFY 2017-18 of 50.01%

Fees and Payments distributed under fully funded model the same as restricted model

**Definitions:**

*Rural hospital* is a hospital not located within a Metropolitan Statistical Area (MSA) or is located within an outlying county of a MSA as designated by the United States Office of Management & Budget.

Note: A Rural hospital is a hospital not located in Boulder, El Paso, Adams, Arapahoe, Broomfield, Denver, Douglas, Jefferson, Larimer, Mesa, Weld, or Pueblo county.

*Critical Access Hospital (CAH)* is a hospital certified under a set of Medicare Conditions of Participation (CoP), which are structured differently than the acute care hospital CoP. Some of the requirements for CAH certification include having no more than 25 inpatient beds; maintaining an annual average length of stay of no more than 96 hours for acute inpatient care; offering 24-hour, 7-day-a-week emergency care; and at least 35 miles drive away from any other hospital or CAH (fewer in some circumstances).
(https://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/critical.html)