MEMORANDUM

TO: Joint Budget Committee

FROM: Eric Kurtz, JBC Staff (303-866-4952)

SUBJECT: Health Care Policy and Financing – tabled items
Limiting Hospital Provider Fee revenue and *Continuous eligibility financing*

DATE: March 18, 2015

Below are two JBC staff recommended changes for the Department of Health Care Policy and Financing that the JBC indicated it would like to revisit after the revenue forecast. The JBC did not discuss the recommendation regarding *Limiting Hospital Provider Fee revenue.* The JBC did discuss the recommendation regarding *Continuous eligibility financing*, but tabled the issue after a 3-3 vote for the JBC staff recommendation.

➔ Limiting Hospital Provider Fee revenue – JBC staff recommendation

Request: The Department's February 2015 forecast assumes the Hospital Provider Fee will be set in FY 2015-16 to maximize revenue within federal limits on the fee. This results in a projected 29.4 percent increase in revenue from the Hospital Provider Fee in FY 2015-16, compared to the allowable TABOR growth rate for revenue statewide of 4.4 percent. The Department's February 2015 forecast assumes the Hospital Provider Fee revenue will grow $133.0 million more than the TABOR growth rate.

Recommendation: Staff recommends that the JBC introduce legislation to reduce the growth in the Hospital Provider Fee revenue by $133.0 million in FY 2015-16. The December forecasts by both Legislative Council Staff and the Office of State Planning and Budgeting indicated a TABOR refund would be due in FY 2015-16. Revenue collected from the Hospital Provider Fee contributes to the projected TABOR refund. All of the mechanisms for making the TABOR refund call for payments from the General Fund. So, the growth in revenue from the Hospital Provider Fee creates a General Fund obligation for the TABOR refund.

The staff recommendation would reduce the General Fund obligation for the TABOR refund by $133.0 million. It would also reduce booster payments to hospitals by a total of $270.4 million, including $133.0 million from the Hospital Provider Fee and $137.3 million from federal funds. These changes do not appear in the summary tables for the line item or the department, because the fiscal impact will be in a separate bill from the Long Bill. The reduction in the General Fund obligation for TABOR will not appear as an appropriation, but rather as a reduction to non-appropriated obligations on the General Fund overview.

Background

What is the Hospital Provider Fee?

The Hospital Provider Fee is an assessment on hospitals that includes one component based on beds filled per day and another component based on a percentage of outpatient charges. There are discounts for high volume Medicaid and Colorado Indigent Care Program providers and

essential access providers. Certain hospitals are exempted from the fee, including psychiatric hospitals, Medicare certified long-term care hospitals, and Medicare certified rehabilitation hospitals.

How is the amount of the Hospital Provider Fee determined?
The Hospital Provider Fee rates are set annually by the Medical Services Board based on recommendations from the Hospital Provider Fee Advisory Board, which features five members from the hospital industry out of a total of eleven members. However, the Department's plan for the Hospital Provider Fee, including both the revenue and expenditures, must be approved by the Centers for Medicare and Medicaid Services (CMS).

There have been delays in CMS approval of the Department's FY 2014-15 Hospital Provider Fee plan, and so the Department is currently operating under the plan approved by CMS for FY 2013-14 that doesn't fully account for the Medicaid expansion authorized by SB 13-200. This helps explain why the Department's projection of FY 2014-15 revenues from the Hospital Provider Fee is so much lower than the Department's projection of FY 2015-16 revenues. The delays in CMS approval are due in part to errors in the original calculations by a contractor helping the Department develop the Hospital Provider Fee plan. Trying to correct these errors and prevent similar future mistakes was among several reasons the Department requested and the JBC approved additional funds through the supplemental process for *S10 Provider fee analytics*. The total approved for S10 was $1,000,000, including $500,000 from the Hospital Provider Fee, but dealing with the delays in CMS approval of the Hospital Provider Fee plan was only one of several parts of the request.

What are the federal limits on the Hospital Provider Fee?
Federal policies limit Hospital Provider Fee revenues to the lesser of the Upper Payment Limit and six percent of net patient revenues. Total Medicaid reimbursements to hospitals from all sources, including the Hospital Provider Fee, may not exceed the federal Upper Payment Limit. There are nuances to the calculation of the UPL, but it can be thought of as the amount Medicare would have paid for the same services.[1] In addition, the Hospital Provider Fee may not exceed six percent of net patient revenue. Net patient revenue is the actual payments received from patients (as opposed to charges to patients) after netting out discounts to insurers and uncompensated care. The net patient revenue limit is on aggregate revenues, rather than per hospital.

Why are the federal limits on the Hospital Provider Fee increasing?
Although there are federal limits on the revenue from the Hospital Provider Fee, these limits are influenced by policy decisions about Medicaid eligibility and benefits. There are separate UPLs

[1] Note that the UPL is estimated using aggregate data and federal formulas and the Department's ability to calculate the UPL for a class of services does not necessarily mean that the Department has detailed information about the incremental difference between individual Medicaid rates and the corresponding Medicare rate. Also, the Department has significantly more information about hospitals than other providers due to federally mandated hospital cost reports.

for different categories of service, so the UPL for hospitals is not the same as the UPL for nursing homes. The amount of room under a given UPL is dependent on the difference between Colorado's Medicaid reimbursement rates and Medicare's reimbursement rates for the category of services. If the Medicaid eligibility criteria or benefits are expanded, then there are more instances of an incremental difference between the Medicaid and Medicare reimbursement and the room beneath the UPL increases.

Similarly, the limit that Hospital Provider Fee revenue may not exceed six percent of net patient revenues is influenced by eligibility and benefit policies. If eligibility and/or benefits are expanded it can increase net patient revenues and thereby raise the limit on the amount of Hospital Provider Fee revenue that can be raised. However, there is a lag between when an increase in eligibility or benefits would occur and when the net patient revenues would increase. Also, Medicaid is only one payer, and so the trend for net patient revenues can be counter to the trend for Medicaid expenditures on hospitals

For FY 2013-14 the most restrictive federal limit was the UPL, but for FY 2014-15 and FY 2015-16 the Department is projecting that the more restricting federal limit will be six percent of net patient revenues. This is because the Department projects the Medicaid expansion will increase the room under the UPL dramatically, significantly increasing the total revenue that can be collected from the Hospital Provider Fee.

How is the Hospital Provider Fee utilized?
Based on how the Hospital Provider Fee is distributed, the primary function of the Hospital Provider Fee is to increase reimbursements to hospitals in the form of booster payments, safety net provider payments, and quality incentive payments. When the Hospital Provider Fee was created the General Fund could not support a significant increase in provider rates. The Hospital Provider Fee allowed a substantial increase for hospitals with no negative impact on the General Fund. For each dollar collected for booster payments and safety net provider payments hospitals receive in aggregate approximately two dollars in return. The distribution formulas for booster payments and safety net provider payments result in some hospitals receiving a larger net benefit and some actually losing money on the exchange, but in aggregate hospitals come out significantly ahead financially by paying the Hospital Provider Fee. The financial incentive for hospitals is to maximize this portion of the Hospital Provider Fee. Even better than paying $1 and getting $2 in return is paying $2 and getting $4 in return.

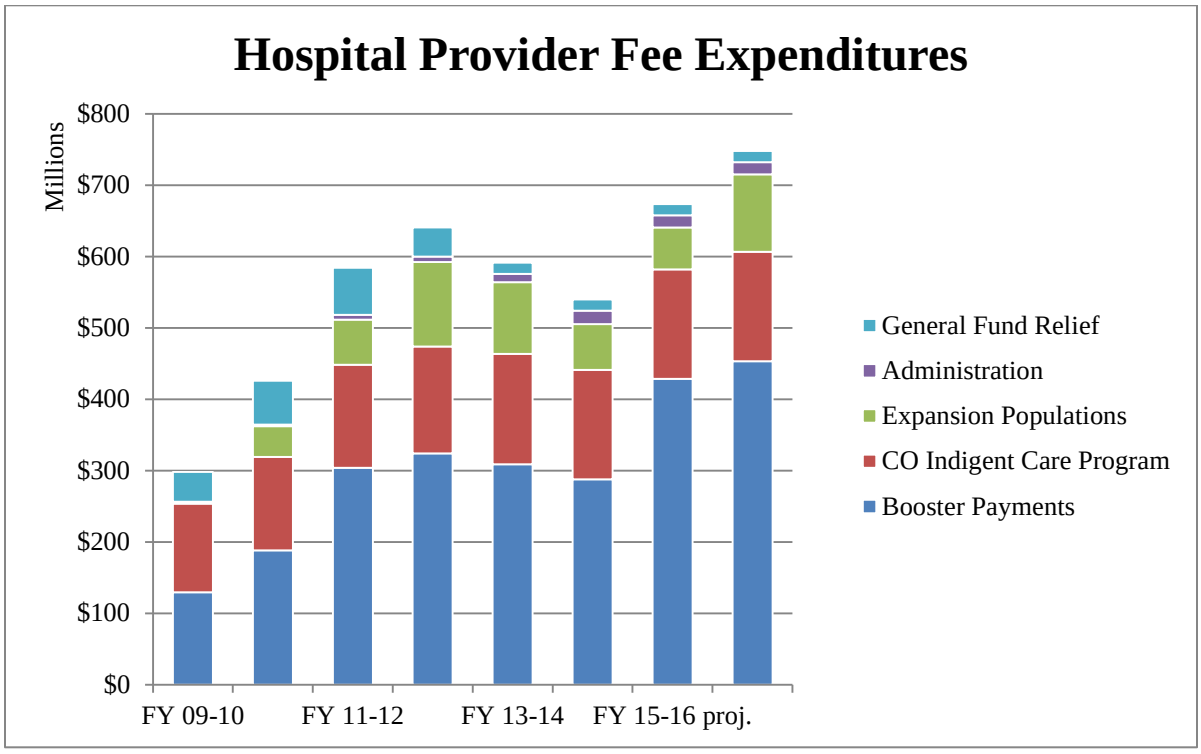
In addition to increasing hospital reimbursement the Hospital Provider Fee also finances Medicaid and CHP+ eligibility expansions. The financial benefit to hospitals from subsidizing the expansion populations is a mixed bag. The eligibility expansions reduce uncompensated care for hospitals, potentially bring in new business for hospitals, and the match rates under the ACA are very favorable. However, some of the money from the Hospital Provider Fee that is used for expansion populations goes to providers other than hospitals. Also, expanding Medicaid and CHP+ eligibility may increase utilization of hospital services and to the extent that Medicaid and CHP+ reimburse below costs this could have a negative effect on hospital budgets compared to if the population did not utilize the services due to a lack of insurance. To varying degrees, depending on the institution, an increased utilization of hospital services may offset more or less

of the value to hospitals of reducing uncompensated care. Trying to quantify the net benefit to hospitals from the portion of the Hospital Provider Fee devoted to financing expansion populations is a complicated and controversial analysis.

A third use of the Hospital Provider Fee is to offset the need for General Fund. Prior to the adoption of the Hospital Provider Fee the General Assembly documented expenditures by local governments to support public hospitals and used these as certified public expenditures to match federal funds for Medicaid reimbursement in lieu of using the General Fund. The Hospital Provider Fee took over the cost off offsetting the General Fund pursuant to Section 25.5-4-402.3 (4)(b)(VII), C.R.S., and continues to pay it at the historic level of $14.5 million per year. In addition to this historic amount, in order to balance the budget the General Assembly has temporarily used significant amounts from the Hospital Provider Fee to offset the need for General Fund for Medical Services Premiums. The temporary use of the Hospital Provider Fee for General Fund relief was essentially in place of a provider rate decrease for hospitals in those years.

The final use of the Hospital Provider Fee is for administrative expenses. These expenses relate to the collection and disbursement of the Hospital Provider Fee and to the management of the expansion populations.

The table below summarizes actual and projected expenditures for each category over time. These are just the expenditures from the Hospital Provider Fee and do not include the matching federal funds.



Where do hospitals get the money to pay for the Hospital Provider Fee? Do they increase charges to patients?
Hospitals get the money for the Hospital Provider Fee from cash on hand to pay future obligations, such as payroll or leased space. The Hospital Provider Fee is collected monthly and the booster payments are disbursed almost as quickly as the money is collected. The Hospital Provider Fee transaction is complete before hospitals need the money for other obligations. There is no need for hospitals to increase charges on patients to pay the Hospital Provider Fee.

Do hospitals like paying the Hospital Provider Fee?
The JBC staff can't speak for the opinions of hospitals, but there is a strong financial incentive for hospitals to support the portion of the Hospital Provider Fee that pays for booster payments and safety net provider payments. General Fund to support these payments would be better for the hospitals, but in the absence of General Fund the JBC staff suspects most hospitals welcome the opportunity to double their money by paying the Hospital Provider Fee. Staff suspects there would be significant opposition from hospitals to reigning in the amount of the Hospital Provider Fee collected for these purposes.

There may be differing opinions on the portion of the Hospital Provider Fee that supports expansion populations. Some of the money for expansion populations goes to providers other than hospitals. Also, as noted previously, expanding eligibility or benefits can result in greater utilization of hospital services that are compensated below cost.

What effect does the Hospital Provider Fee have on the TABOR refund?
If the state owes a TABOR refund, as projected by both Legislative Council Staff and OSPB in both FY 2014-15 and FY 2015-16, an increase in revenue from the Hospital Provider Fee will increase the TABOR refund. Revenue from the Hospital Provider Fee is subject to the TABOR limit, but the federal matching funds are exempt. The current TABOR refund mechanisms make all of the payments from the General Fund. So, an increase in Hospital Provider Fee revenue increases the General Fund obligation for the TABOR refund.

The contributions of cash funds to the TABOR refund are often measured based on the growth rate of the cash fund relative to the growth of the TABOR limit. If a cash revenue source is growing faster than the TABOR limit allows, then the difference increases the General Fund obligation compared to if the cash revenue source did not exist. Conversely, if the cash revenue is growing slower than the TABOR limit allows, then the cash revenue source results in a lower General Fund refund obligation than if the cash revenue source did not exist.

For FY 2015-16 the Department is projecting a significant increase in Hospital Provider Fee revenue compared to the growth in the TABOR limit.

Hospital Provider Fee Revenue	
FY 14-15 Revenue	$532,708,137
FY 15-16 Revenue	$689,195,211
Dollar change from FY 14-15	$156,487,074
Percent	29.4%

Hospital Provider Fee Revenue	
TABOR allowable growth	4.4%
FY 15-16 Revenue at TABOR rate	$556,147,295
Dollar change from FY 14-15	$23,439,158
FY 15-16 Revenue above TABOR	$133,047,916

What happens to the Hospital Provider Fee revenue if the General Assembly approves a new expenditure from the Hospital Provider Fee?
The Hospital Provider Fee model is built to maximize revenue within the federal limits, and so a policy change that increases expenditures will not directly change the revenue projection. However, there could be an indirect effect on the revenue projection if the policy change results in an increase in the federal limits. This could happen if the policy change increases the available room under the Upper Payment Limit or increases hospital net patient revenues, such as a policy change that expands eligibility or benefits.

Rationale for the recommendation
With a projected TABOR refund due in FY 2015-16, growth in revenue from the Hospital Provider Fee creates a General Fund obligation. This means that increasing compensation for hospitals with financing from the Hospital Provider Fee is just as expensive for the General Fund as a provider rate increase, or an increase in K-12 per pupil funding, or an increase in higher education stipends. However, under the current statutory framework for the Hospital Provider Fee, increased compensation for hospitals will just happen without competing with other potential General Fund expenditure priorities through the budget process.

When the Hospital Provider Fee was created a TABOR refund was not due, and so the General Assembly was able to increase compensation for hospitals with no negative impact on the General Fund. Now that the overall budget outlook has changed, the JBC staff believes it is appropriate and necessary to reexamine the Hospital Provider Fee and put some limits on the growth in revenue.

In order to limit the Hospital Provider Fee revenue, the JBC staff believes a statutory change is necessary. Section 25.5-4-402.3 (3) (b) (III), C.R.S. requires the Medical Services Board to establish the Hospital Provider Fee so that revenues are approximately equal to or less than the appropriation. The General Assembly could just lower the appropriation in the Long Bill to reduce revenues from the Hospital Provider Fee. However, doing so could result in a decrease in eligibility or benefits, due to the prioritized uses of the Hospital Provider Fee in Section 25.5-4-402.3 (5) (b) (II), C.R.S., which requires full funding of booster payments (among other things) before financing expansion populations. Reducing eligibility or benefits would likely result in noncompliance with the minimum federal standards for receiving an enhanced federal match for populations that are "newly eligible" pursuant to the ACA, which would dramatically increase the state's General Fund costs. If the JBC wants to reduce Hospital Provider Fee revenues, but does not want to reduce eligibility or benefits, then the safest course of action is legislation. Otherwise, the Medical Services Board will need to determine what "fully funded" booster payments mean, and the JBC may not like the results, and/or there could be a legal challenge from hospitals.

Even if the JBC decides not to restrict Hospital Provider Fee revenues in FY 2015-16, staff believes the prioritized uses of the Hospital Provider Fee in Section 25.5-4-402.3 (5) (b) (II), C.R.S., are problematic. The JBC staff believes the current prioritization is the exact opposite of what would serve the General Assembly best. Staff believes the Hospital Provider Fee should first ensure coverage of the expansion populations and only then increase reimbursements to hospitals with available remaining revenue. Staff would recommend a change to the prioritization whether the JBC decides to restrict revenue or not, but this is likely to be controversial legislation and there is less urgency in FY 2015-16 to change the prioritization if the JBC does not want to pursue the staff recommendation to restrict revenue.

The JBC staff is recommending a reduction in the Hospital Provider Fee revenue of $133.0 million based on the difference between the TABOR allowable growth and HCPF's February 2015 projection of growth for the Hospital Provider Fee. The JBC could allow the hospitals to generate more revenue from the Hospital Provider Fee, but the cost to the state budget would be the same as if the JBC appropriated General Fund to the hospitals. From the perspective of the hospitals, it would be much better to have a dollar of General Fund than a dollar of Hospital Provider Fee. When a hospital pays $1 of Hospital Provider Fee they get $2 in return for a net benefit of $1, but when the state pays $1 in General Fund the hospital gets $2 and doesn't have to give up anything (except state taxes, which would be a liability in either scenario).

If the JBC feels that a $133.0 million dollar reduction in revenue from the Hospital Provider Fee creates a burden on hospitals, the JBC could choose to backfill all or some of the loss with an increase in hospital rates. The JBC staff recommendation is to simply limit Hospital Provider Fee revenue by $133.0 million, but the table below illustrates an option where General Fund for provider rate increases is substituted for Hospital Provider Fee for booster payments.

Limiting Hospital Provider Fee Revenue							
	Expenditures	Inpatient	Outpatient	Safety Net	Booster	HPF Obligation for Safety Net/ Booster	Net Effect
FY 14-15 Estimate	$2,153,044,483	$685,188,429	$571,763,766	$311,296,186	$584,796,102	($440,967,015)	$1,712,077,468
Enrollment/utilization trend 10.5%	193,950,628	72,155,748	60,211,236	0	61,583,644	(30,305,311)	163,645,317
Subtotal FY 15-16 base	$2,346,995,111	$757,344,177	$631,975,002	$311,296,186	$646,379,746	($471,272,326)	$1,875,722,785
Policy Changes							
Provider rate increases	230,736,311	3,495,435	2,916,808	0	224,324,068	(110,389,874)	120,346,437
Continuous eligibility - FY 15-16	(42,715,698)	0	0	0	(42,715,698)	0	(42,715,698)
Continuous eligibility - retroactive	(37,467,299)	0	0	0	(37,467,299)	0	(37,467,299)
Limit HPF revenue by $133.0 M	(270,367,641)	0	0	0	(270,367,641)	133,047,916	(137,319,725)
Subtotal policy changes	($119,814,327)	$3,495,435	$2,916,808	$0	($126,226,570)	$22,658,042	($97,156,285)
Percent change	-5.1%	0.5%	0.5%	0.0%	-19.5%	-4.8%	-5.2%
Optional increase hospital rates							
General Fund	31,718,925	17,290,587	14,428,338	0	0	0	31,718,925
Cash Funds	1,221,666	665,953	555,713	0	0	0	1,221,666
Federal Funds	73,594,308	40,117,650	33,476,658	0	0	0	73,594,308
TOTAL	$106,534,899	$58,074,190	$48,460,709	$0	$0	$0	$106,534,899
Policy changes w/ optional rate inc.	($13,279,428)	$61,569,625	$51,377,517	$0	($126,226,570)	$22,658,042	$9,378,614
Percent change	-0.6%	8.1%	8.1%	0.0%	-19.5%	-4.8%	0.5%

Following is an explanation of the column headings. The Expenditures column sums expenditures for inpatient and outpatient services that are paid on the Department's fee schedule with safety net provider payments and booster payments. All of these figures are total funds, including the matching federal funds. The HPF Obligation for Safety Net/Booster column shows the amount hospitals have to pay for safety net and booster payments. To simplify the analysis this table does not include the Hospital Provider Fee obligations for expansion populations, although some of the payments for inpatient and outpatient services are related to expansion populations. The Net Effect column is the value of the expenditures less the hospital provider fee obligation.

Key assumptions for the rows are explained in this paragraph. The "Enrollment/utilization trend 10.5%" row is based on the Department's February 2015 forecasted increase in acute care expenditures. For the Booster column the JBC attributed a portion of the overall projected $285.9 million increase in booster payments to the enrollment and utilization trend. The remainder appears in the "Provider rate increases" row. The "Provider rate increases" for inpatient and outpatient services are based on the JBC's common policy 0.5 percent increase and do not include any portion of the targeted rate increases, although some of the targeted rate increases may effect hospitals. The two "Continuous eligibility" rows show the effect of the JBC's staff recommendation on the hospitals. The totals here include the matching federal funds, and so are slightly more than twice the cut in Hospital Provider Fee associated with the staff recommendation regarding continuous eligibility financing. The "Limit HPF revenue by $133.0 M" row shows the staff assumption about the reduction in booster payments that would occur.

The combined impact of all the recommended policy changes is a 5.2 percent reduction in hospital compensation, including safety net and booster payments.

The "Optional increase hospital rates" presents a scenario where the JBC would backfill a portion of the lost revenue to hospitals from booster payments with an increase in hospital rates. Because of the favorable FMAP rates for expansion populations, the General Fund required to fully backfill the loss in booster payments would be less than the decrease in the Hospital Provider Fee. This scenario does not fully backfill the loss in booster payments, but rather provides an increase in hospital rates so that the Net Effect for hospitals is a 0.5 percent increase, consistent with the JBC's common policy.

The previous table showed the combined effect of both the staff recommendation for continuous eligibility financing and the staff recommendation for limiting hospital provider fee revenue, along with an optional increase in hospital rates. The next table isolates the ramifications for the General Fund and for the hospitals of just the recommendation to limit hospital provider fee revenue and the optional increase in hospital rates.

Net General Fund benefit from limiting HPF revenue	
TABOR Refund	($133,047,916)
Optional increase in hospital rates	31,718,925
TOTAL	($101,328,991)
Net hospital loss from limiting HPF revenue	
Reduced HPF obligation	$133,047,916
Booster payments	(270,367,641)
Optional increase hospital rates	106,534,899
TOTAL	($30,784,826)

Depending on the March revenue forecasts, the decrease in the General Fund obligation for the TABOR refund may benefit the capital construction and highway budgets more than the operating budget. Based on the Legislative Council Staff's December forecast, a decrease in the TABOR refund of $133.0 million would drop the TABOR refund to below 1.0 percent, triggering an increase in required transfers to the Capital Construction Fund and Highway Users Tax Fund of $25.6 million and $102.5 million respectively. However, the March revenue forecasts may change assumptions about the size of the TABOR refund. Also, the General Assembly could modify the transfers to the Capital Construction Fund and the Highway Users Tax Fund. The JBC staff cannot evaluate this potential secondary ramification of the recommendation until the March revenue forecasts are available.

If the JBC decided to do the optional increase in hospital rates, it could change the distribution of funds to hospitals compared to if the money was allocated through booster payments. The Department would need to analyze the extent to which the rate increases and/or remaining booster payments could be customized to result in a similar distribution to the status quo, if that is a goal of the JBC.

➔ Continuous eligibility financing (JBC staff recommendation)

Request: Built into the Department's February 2015 forecast is an assumption that the state share of continuous eligibility for children will be financed with the Hospital Provider Fee. Continuous eligibility is a policy that once Medicaid eligibility is determined the person remains eligible for a period of one year. Continuous eligibility for children was authorized in H.B. 09-1293, but the Department did not implement it until S.B. 13-200 was adopted, based on a determination that there were insufficient funds from the Hospital Provider Fee. The assumption in the February forecast is a change from the November request, when the Department assumed that the state share of costs for continuous eligibility would be financed with the General Fund. However, the JBC staff believes the Department is still not estimating the cost of continuous eligibility in a manner consistent with the statute.

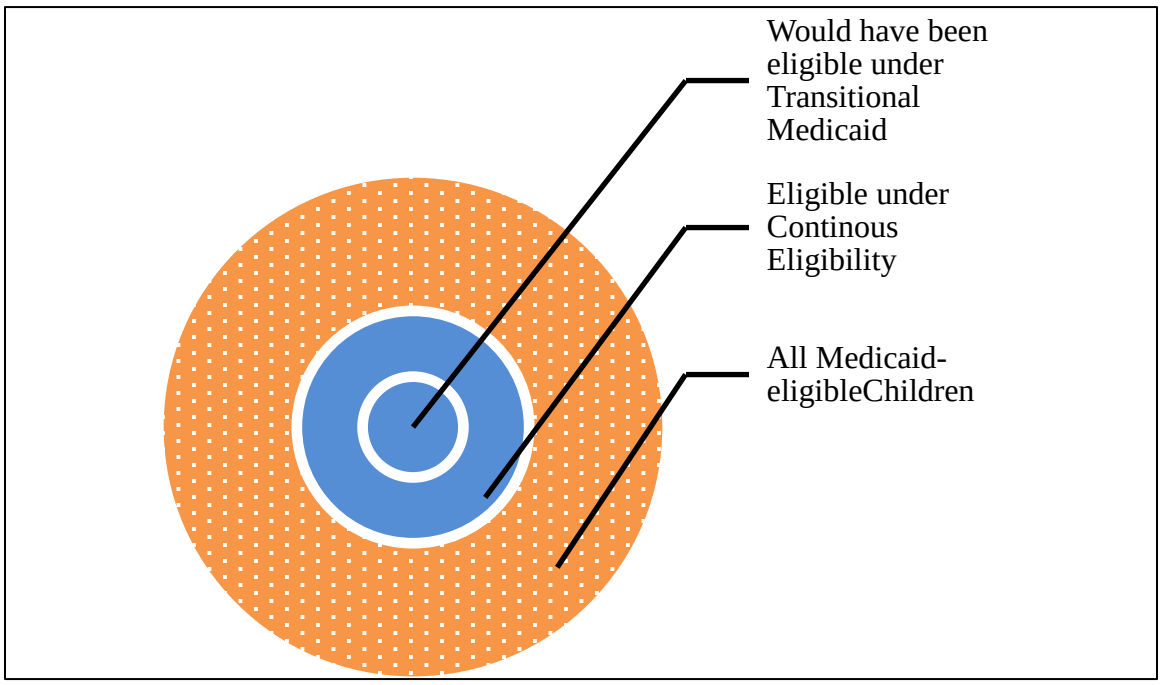
Recommendation: Staff recommends a reduction in General Fund and a corresponding increase in appropriations from the Hospital Provider Fee of $39.5 million in FY 2015-16 to more accurately reflect the state share of costs for continuous eligibility for children. This adjustment is composed of $21.0 million for continuous eligibility costs in FY 2015-16, which is roughly the on-going correction expected in future years, and $18.4 million for retroactive adjustments for FY 2014-15 and FY 2013-14.

Prior to the implementation of continuous eligibility for children, there was a population of children who experienced an increase in income and remained eligible for Medicaid as a result of Transitional Medicaid. Transitional Medicaid is a federally required program that allows people who have been eligible for Medicaid for at least three of the last six months to remain eligible for a period of up to one year, if they would otherwise lose eligibility due to an increase in income. The incremental cost of implementing continuous eligibility was estimated as the difference between the children eligible based on Transitional Medicaid and the children expected to be eligible based on continuous eligibility.

Since the implementation of continuous eligibility, the population of children eligible based on Transitional Medicaid has been diminishing. This is because the Department tests for eligibility under the continuous eligibility criteria, finds the applicants eligible, and then never needs to test for eligibility based on the Transitional Medicaid criteria. The population traditionally eligible for Transitional Medicaid is being consumed by continuous eligibility.

The Department's February 2015 forecast assumes that the cost for continuous eligibility that needs to be financed from the Hospital Provider Fee is the difference between the number of children who would have been eligible under Transitional Medicaid and the children actually eligible under continuous eligibility. Because the Department doesn't know how many children would have been eligible under Transitional Medicaid, the Department makes a projection based on the population on Transitional Medicaid prior to the implementation of continuous eligibility.

In the Venn diagram below the Department is trying to finance the donut between the children who would have been eligible under Transitional Medicaid and the children eligible under continuous eligibility.



The JBC staff does not believe the Department's interpretation of the costs of continuous eligibility to be financed with the Hospital Provider Fee is consistent with the statute. The statute does not say that the Hospital Provider Fee will pay for the difference in costs between an estimate of the Transitional Medicaid population and the continuous eligibility population. Rather, Section 25.5-4-402.3 (4) (b) (V), C.R.S., says the Hospital Provider Fee shall be used, "to provide continuous eligibility for twelve months for children enrolled in the state medical assistance program." Another statute, Section 25.5-5-204.5, C.R.S., describes who qualifies for continuous eligibility, and it does not exclude children who would otherwise have been eligible for Transitional Medicaid.

In the Venn diagram above the staff position is that the Hospital Provider Fee should fund the entire solid blue area, both the children eligible under continuous eligibility and the children who would have been eligible under Transitional Medicaid. The competing policies can be described as the donut versus the hole.

In addition to the JBC staff's concern about the Department's interpretation of the statute, the JBC staff has a practical concern about the Department's ability to accurately identify the number of children who would have been eligible for Transitional Medicaid absent continuous eligibility. The more time passes from when Transitional Medicaid for children mattered, the less accurate the forecast. Because the Department's estimate is not verifiable, the amount allocated from the Hospital Provider Fee for continuous eligibility could be subject to manipulation during annual negotiations on the Hospital Provider Fee plan.

The fiscal note for S.B. 13-200 correctly identified the incremental cost of continuous eligibility in the initial year, but it failed to account for continuous eligibility consuming Transitional

Medicaid in future years. Staff views this as an error in assumptions in the fiscal note. There was a consequence of the General Assembly's policy that was not foreseen. Possibly this was an unintended consequence, but that is not known. An error in the fiscal note assumptions about the future year costs of a policy should not govern the interpretation of the plain meaning of the statute.

If the General Assembly agrees with the JBC staff's interpretation of the statute, then the Department under-collected from the Hospital Provider Fee for the costs of continuous eligibility since the policy was implemented in March 2014. It follows that the Department should recover the underpayments at the earliest practical date, which the JBC staff assumes would be FY 2015-16, based on the time required to make changes to the Hospital Provider Fee plan. The retroactive recovery may seem punitive to people not immersed in Medicaid financing, but it is really not unusual. The Department regularly makes reconciliations with providers for under- or over-payments, often for activities from several years in the past. Similarly, the federal government will make reconciliations with Colorado for practices from several years ago.

The table below summarizes the JBC staff estimate of the cost of financing the population that would have been eligible for Transitional Medicaid with money from the Hospital Provider Fee.

Continuous Eligibility for Children				
	FY 2013-14	FY 2014-15	FY 2015-16	Cumulative
Assumptions				
Caseload	4,984	23,235	31,388	
Medical Services Premiums per capita	$1,708.01	$1,745.72	$1,756.32	
Behavioral Health per capita	$209.54	$226.92	$236.24	
Average FMAP	50.90%	52.16%	54.14%	
JBC Staff forecast of costs				
Medical Services Premiums	$8,511,868	$40,561,278	$55,127,264	
Hospital Provider Fee	4,179,682	19,402,648	25,281,977	
Federal Funds	4,332,186	21,158,630	29,845,287	
Behavioral Health	$1,044,243	$5,272,418	$7,415,087	
Hospital Provider Fee	512,767	2,522,082	3,400,642	
Federal Funds	531,476	2,750,336	4,014,445	
TOTAL	$9,556,111	$45,833,696	$62,542,351	
Hospital Provider Fee	4,692,449	21,924,730	28,682,619	
Federal Funds	4,863,662	23,908,966	33,859,732	
February 2015 HCPF projection of Hospital Provider Fee Costs				
Medical Services Premiums	1,518,521	6,431,818	7,662,224	
Behavioral Health	229,183	0	0	
TOTAL Hospital Provider Fee	$1,747,704	$6,431,818	$7,662,224	
Difference				
Medical Services Premiums				
General Fund	($2,661,162)	($12,970,831)	($17,619,753)	($33,251,745)
Hospital Provider Fee	$2,661,162	$12,970,831	$17,619,753	$33,251,745

Continuous Eligibility for Children	FY 2013-14	FY 2014-15	FY 2015-16	Cumulative
Behavioral Health				
General Fund	($283,584)	($2,522,082)	($3,400,642)	($6,206,308)
Hospital Provider Fee	$283,584	$2,522,082	$3,400,642	$6,206,308
TOTAL				
General Fund	($2,944,746)	($15,492,913)	($21,020,395)	**($39,458,053)**
Hospital Provider Fee	$2,944,746	$15,492,913	$21,020,395	**$39,458,053**

Implementing the JBC staff recommendation would save a total of $39.5 million General Fund in FY 2015-16. It would not change the projected Hospital Provider Fee revenues, because the projection is that the Hospital Provider Fee will be set to maximize revenue within the federal limits (revenues from the Hospital Provider Fee and the federal limits are discussed in more detail below, under *Limiting Hospital Provider Fee revenue – JBC staff recommendation*). It would change the allocation of the Hospital Provider Fee. More money would be needed for continuous eligibility and less money would be available for other priorities, which is financially disadvantageous to hospitals.

The JBC staff assumes the costs for continuous eligibility would come out of booster payments, but the JBC staff believes it would be acceptable if the Department took the costs out of Safety Net Provider Payments and submitted a supplemental request to true up the appropriations. The total loss to booster payments would be $80,182,997, including $39,458,053 Hospital Provider Fee and $40,724,944 federal funds. The increase in Hospital Provider Fee expenditures for continuous eligibility is completely offset by the decrease in Hospital Provider Fee expenditures for booster payments for no net change in Hospital Provider Fee appropriations.

In Section 25.5-5-204.5 (2), C.R.S., the Medical Services Board is allowed to eliminate continuous eligibility for children if the revenue from the Hospital Provider Fee is insufficient to "fully fund" all of the purposes of the Hospital Provider Fee. However, the term "fully fund" is not defined. The JBC staff does not know under what circumstances the Medical Services Board would eliminate continuous eligibility for children rather than reducing booster payments, but it seems unlikely that the Medical Services Board would adopt such a policy. In Section 25.5-4-402.3, C.R.S. there is a prioritization of the uses of the Hospital Provider Fee that indicates booster payments, among other things, should be "fully funded" before certain expansion populations, but continuous eligibility for children is not listed among those expansion populations. The statues are silent on the prioritization of continuous eligibility for children versus booster payments.