Schedule 13
Change Request for FY 2009-10 Budget Request Cycle

Decision Item FY 2009-10	Base Reduction Item FY 2009-10	Supplemental FY 2008-09 ☑	Budget Amendment FY 2009-10

Request Title: Revised Implementation of SB 06-145 Local Government Provider Fee
Department: Health Care Policy and Financing — **Dept. Approval by:** John Bartholomew JB — **Date:** January 2, 2009 12/15/08
Priority Number: S-16 — **OSPB Approval:** — **Date:** 12-18-08

	Fund	1 Prior-Year Actual FY 2007-08	2 Appropriation FY 2008-09	3 Supplemental Request FY 2008-09	4 Total Revised Request FY 2008-09	5 Base Request FY 2009-10	6 Decision/ Base Reduction FY 2009-10	7 November 1 Request FY 2009-10	8 Budget Amendment FY 2009-10	9 Total Revised Request FY 2009-10	10 Change from Base (Column 5) FY 2010-11
Total of All Line Items	Total	10,211,350	5,205,696	(5,205,696)	0	5,205,696	0	5,205,696	0	5,205,696	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	2,602,848	(2,602,848)	0	2,602,848	0	2,602,848	0	2,602,848	0
	CFE/RF	5,105,675	0	0	0	0	0	0	0	0	0
	FF	5,105,675	2,602,848	(2,602,848)	0	2,602,848	0	2,602,848	0	2,602,848	0
(4) Indigent Care Program, S.B. 06-145 Inpatient Provider Fee	Total	4,225,858	2,154,322	(2,154,322)	0	2,154,322	0	2,154,322	0	2,154,322	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	1,077,161	(1,077,161)	0	1,077,161	0	1,077,161	0	1,077,161	0
	CFE/RF	2,112,929	0	0	0	0	0	0	0	0	0
	FF	2,112,929	1,077,161	(1,077,161)	0	1,077,161	0	1,077,161	0	1,077,161	0
(4) Indigent Care Program, S.B. 06-145 Outpatient Provider Fee	Total	5,985,492	3,051,374	(3,051,374)	0	3,051,374	0	3,051,374	0	3,051,374	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	1,525,687	(1,525,687)	0	1,525,687	0	1,525,687	0	1,525,687	0
	CFE/RF	2,992,746	0	0	0	0	0	0	0	0	0
	FF	2,992,746	1,525,687	(1,525,687)	0	1,525,687	0	1,525,687	0	1,525,687	0

Non-Line Item Request: None
Letternote Revised Text: None
Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX
Reappropriated Funds Source, by Department and Line Item Name: N/A
Approval by OIT? Yes: ☐ No: ☐ N/A: ☑
Schedule 13s from Affected Departments: N/A

CHANGE REQUEST for FY 2009-10 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	S-16
Change Request Title:	Revised Implementation of SB 06-145 Local Government Provider Fee

SELECT ONE (click on box):

☐ Decision Item FY 2009-10
☐ Base Reduction Item FY 2009-10
☒ Supplemental Request FY 2008-09
☐ Budget Request Amendment FY 2009-10

SELECT ONE (click on box):

Supplemental or Budget Request Amendment Criterion:

☐ Not a Supplemental or Budget Request Amendment
☐ An emergency
☐ A technical error which has a substantial effect on the operation of the program
☐ New data resulting in substantial changes in funding needs
☒ Unforeseen contingency such as a significant workload change

Short Summary of Request: This request is for removal of funding for the Department's (4) Indigent Care Program; SB 06-145 Inpatient Provider Fee and the (4) Indigent Care Program; SB 06-145 Outpatient Provider Fee line items from the FY 2008-09 Budget. The change would only be needed for FY 2008-09 as the Department has included these funds in the November 3, 2008 FY 2009-10 Budget Request. The removal of this funding would represent a reduction in cash funds spending authority of $5,205,696 in FY 2008-09.

Background and Appropriation History: During the 2006 legislative session, the General Assembly passed SB 06-145, "Concerning the Authority of a Local Government to Impose a Fee on Certain Medical Providers for Purposes of Obtaining Federal Financial Participation under Medicaid for Unreimbursed Medicaid Costs." This statute authorized local governments to assess a fee on the revenues of private hospitals within their jurisdiction that provide inpatient and/or outpatient medical services subject to 42 CFR §433.68. The monies collected from the fee were to be supplemented with federal Medicaid funds, subject to the available upper payment limit (UPL), and redistributed to private hospitals based on their unreimbursed costs of treating Medicaid and Colorado Indigent Care Program clients. Local

Government participation is voluntary, but participation by hospital providers within participating local governments is mandatory (29-28-103 (1) (a), C.R.S. (2008)).

The Department determined this legislation to have a conditional fiscal impact in FY 2006-07 and FY 2007-08 should local governments elect to impose a fee on private hospital providers within their jurisdiction. As the single State agency authorized to distribute federal Medicaid funds, the Department was required to submit a State Plan Amendment to the Centers for Medicare and Medicaid Services authorizing the reimbursement methodology before federal funding could be drawn and provider payments issued. After the passage of SB 06-145, the Department developed a reimbursement methodology and submitted two State Plan Amendments (Transmittal Number 06-013 for Inpatient Hospital Services and Transmittal Number 06-014 for Outpatient Hospital Services) on September 29, 2006 to the Centers for Medicare and Medicaid Services. At this time, only one local government entity — City of Brighton — has informed the Department of their intention to impose a provider fee on inpatient and outpatient hospital revenues on their sole private hospital provider, Platte Valley Medical Center. See S-17, BA-11 in the Department's January 2, 2008 FY 07-08 Supplemental Requests for more details on the proposed reimbursement methodology.

On January 2, 2008, the Department submitted a Supplemental Request and an associated FY 2008-09 Budget Request Amendment (S-17, BA-11) to appropriate funding to the newly created (4) Indigent Care Program; SB 06-145 Inpatient Provider Fee and the (4) Indigent Care Program; SB 06-145 Outpatient Provider Fee line items. The Department was subsequently appropriated spending authorities of $4,225,858 and $5,985,492 for the Inpatient and Outpatient Provider Fee line items, respectively, which included retroactive funding for fees that would have been collected in FY 2006-07 had the program been operational. At the time that these requests were written, the Department did not anticipate difficulty in obtaining federal matching funds for the new line items. Therefore a payable was set up to retain the FY 2007-08 appropriation for reimbursement of potential fee collections retroactive to FY 2006-07, pending approval of State Plan Amendments submitted under Transmittal Numbers 06-013 and 06-014. However, as the State Plan Amendments have not been approved as originally written, the Department will be

reverting the payable associated with the FY 2007-08 appropriations to these line items. For FY 2008-09, the Department was appropriated a spending authority of $2,154,322 and $3,051,374 for the Inpatient and Outpatient Provider Fee line items, which will not be utilized due to continuing delays in the approval of the Department's reimbursement methodology.

General Description of Request: This request is for removal of funding for the Department's (4) Indigent Care Program; SB 06-145 Inpatient Provider Fee and the (4) Indigent Care Program; SB 06-145 Outpatient Provider Fee line items from the FY 2008-09 Budget. The change would be one time as the Department is requesting replacement of these funds for FY 2009-10. The removal of this funding would represent a reduction in cash funds spending authority of $5,205,696 in FY 2008-09.

The request is needed due to denial of the Department's State Plan Amendments (Transmittal Number 06-013 and Transmittal Number 06-014) concerning the local government provider fee. The federal Centers for Medicare and Medicaid Services concluded that the Department's reimbursement methodology did not meet the requirements of 42 CFR §433.68 (f) addressing hold harmless arrangements. In general, a health care related provider fee must:

- Be broad-based;
- Be uniform, and;
- Avoid hold harmless arrangements.

According to the definition of a qualified provider at 29-28-102 (3) C.R.S. (2008), public hospitals are exempt from the imposition of the local government provider fee. Therefore, if there are public hospitals within the jurisdiction of a participating local government, then the Department must request a waiver of the "broad-based" requirements established under 42 CFR §433.68(c)(2) from the Centers for Medicare and Medicaid Services to exclude the public hospitals from being assessed the provider fee. This regulation establishes that "if a health care-related tax is imposed by a unit of local government, the tax must extend to all items or services or providers (or to all providers in a class) in the

area over which the unit of local government has jurisdiction." Given the legislative restriction in SB 06-145, the Department must request a waiver from the Centers for Medicare and Medicaid Services of the broad-based requirement, pursuant to 42 CFR §433.72(b), to exclude state-owned hospitals within the territorial boundaries of a participating local government from the proposed provider fee. Should the Centers for Medicare and Medicaid Services deny the waiver request, then federal financial participation could not be obtained for provider fees assessed on any provider (private or public) residing within the jurisdiction of that local government.

In addition, assessment of the fee must be uniform, meaning that a participating government must assess all providers, for a specific health care class of service, at the same rate (42 §CFR 433.68 (d)). Since Platte Valley Medical Center is the only provider of inpatient and outpatient services within the City of Brighton, the uniformity requirement is not in question. However, if the Department is able to implement a local government provider fee with additional participating local government entities, the Department will need to ensure adherence to the uniformity requirement.

Health-care related provider fees must also avoid hold harmless situations in order to be considered for approval by the Centers for Medicare and Medicaid Services. The Centers for Medicare and Medicaid Services identifies hold harmless arrangements using the following conditions:

- The State (or other unit of government) imposing the tax provides directly or indirectly for a non-Medicaid payment to those providers or others paying the tax and the amount of the payment is positively correlated to either the amount of the tax or to the difference between the Medicaid payment and the total tax cost;
- All or any portion of the Medicaid payment to the taxpayer varies based only on the amount of the total tax payment, and;
- The State (or other unit of local government) imposing the tax provides, directly or indirectly, for any payment, offset, or waiver that guarantees to hold taxpayers harmless for all or a portion of the tax.

The Department's proposed reimbursement methodology was found to fulfill the last of these provisions (42 CFR 433.68 (f) (3)), and therefore did not avoid a hold harmless arrangement. In a communication to the Department dated August 29th, 2008, the Centers for Medicare and Medicaid Services explained that the current arrangement with the City of Brighton and Platte Valley Medical Center does not meet the avoidance of hold harmless requirements. Since Platte Valley Medical Center is the only provider within the City of Brighton assessed a fee and the only recipient of the proposed payment, the Centers for Medicare and Medicaid Services views the arrangement as a guarantee of final payment in which there is a dollar-for-dollar correspondence between the fee collected and the associated final payment to the provider. Since the Centers for Medicare and Medicaid Services will not approve State Plan Amendments (TN 06-013 and TN 06-014) that would provide federal financial participation for the SB 06-145 payments to Platte Valley Medical Center appropriated in the FY 2008-09 Long Bill, the Department requests that all funding for this line item be removed for FY 2008-09.

However, the Department is exploring alternatives to the proposed provider fee that would ensure approval of associated State Plan Amendments, but at this time is not certain of the outcome. Although it is unlikely that the approval and implementation of a revised provider fee would be complete in time to utilize the appropriated funding in FY 2008-09, the Department requests that the funding be left in the FY 2009-10 in order to safeguard against a lack of spending authority in the case that the revised provider fee can be implemented for FY 2009-10.

Consequences if Not Funded:

Disapproval of this request would create inaccuracy in the Department's budget documents pertaining to the (4) Indigent Care Program long bill group.

Calculations for Request:

Summary of Request FY 2008-09	Total Funds	Cash Funds	Federal Funds
Total Request	($5,205,696)	($2,602,848)	($2,602,848)
(4) Indigent Care Program; SB 06-145 Inpatient Provider Fee	($2,154,322)	($1,077,161)	($1,077,161)
(4) Indigent Care Program; SB 06-145 Outpatient Provider Fee	($3,051,374)	($1,525,687)	($1,525,687)

Cash Funds Projections: Not Applicable.

Assumptions for Calculations: The Department assumes that an amount equal to that initially requested for FY 2008-09 will be required in FY 2009-10. It is assumed that the revision of the provider fee program will be complete with sufficient time to utilize the FY 2009-10 spending authority.

Impact on Other Government Agencies: None.

Cost Benefit Analysis: Not Applicable.

Implementation Schedule: Not applicable.

Statutory and Federal Authority: 29-28-103 (1) (a), C.R.S. (2008). Powers of the governing body - fee authorization - unreimbursed Medicaid costs. *The governing body of a local government may impose a fee on a qualified provider located within its territorial boundaries for the purpose of obtaining federal financial participation under the state's medical assistance program, articles 4, 5, and 6 of title 25.5, C.R.S., to reimburse qualified providers for unreimbursed Medicaid costs.*

25.5-4-417 (4), C.R.S. (2008). Unreimbursed costs - Medicaid providers - state plan amendment - rules. *Upon notice of the imposition of a fee by a local government as authorized by article 28 of title 29, C.R.S., the state department shall calculate the unreimbursed Medicaid costs for qualified providers within the local government, excluding any specific costs the local government exempts from the calculation pursuant to section 29-28-103 (1) (b), C.R.S.*

42 C.F.R §433.68. Permissible health care-related taxes after the transition period. *(a) General rule. Beginning on the day after a State's transition period, as defined in Sec 433.58(b), ends, a State may receive health care-related taxes, without a reduction in FFP, only in accordance with the requirements of this section.*

Performance Measures: Not applicable.