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The Hospital Provider Fee Fund:

A Tax Disguised as a 'Fee' to Artificially Inflate Medicaid Costs, Supplement State Revenues, Expand the Medicaid Program, and Disproportionally Redistribute Funds Among Colorado Hospitals

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WHAT IS THE HOSPITAL PROVIDER FEE?

In 2009, the Colorado General Assembly passed the Colorado Health Care Affordability Act of 2009, HB 09-1293, which imposed an up to 5.5 percent charge on hospital bills. It created the Hospital Provider Fee Cash Fund and the Hospital Provider Fee Oversight and Advisory Board within the Department of Health Care Policy and Financing (HCPF). Funds raised by the provider charge are deposited in the Cash Fund and do not revert to the General Fund. Payments made to hospitals by the Cash Fund are supplemental payments over and above Medicaid reimbursements made to hospitals for services rendered.

THE PROVIDER FEE RAISES REVENUE FOR THE STATE

In FY 2014-15 provider charges collected \$688 million. The revenue comes from payments of the charge and increases in federal Medicaid matching funds. Suppose a day in the hospital costs \$1,000. If the federal match is 50 percent, Colorado Medicaid pays the hospital \$1,000 and receives \$500 from the federal government. Its net cost is \$500.

If the state imposes a \$100 "fee" on hospital bills, the \$1,000 hospital bill

becomes \$1,100. Colorado Medicaid pays the hospital \$1,100. The hospital sends \$100 to the Hospital Provider Fee Cash Fund and Colorado Medicaid receives \$550 in matching funds from the federal government. Net inflows to the state are \$650. Even if the entire \$100 is returned to the hospital as a supplemental payment, the "fee" reduces the state's net cost for a day in the hospital to \$450. Private payers pay more. Their hospital bill is \$1,100 rather than \$1,000. Their hospital sends \$100 to the Hospital Provider Fee Cash Fund. While it may get the money back, its patients do not.

The bulk of the money is distributed to hospitals to supplement Medicaid reimbursements. Rather than paying hospitals for services rendered or giving Medicaid patients the power to reward good hospitals by choosing to use them, it simply pays hospitals for their costs, their location, their participation in Medicaid, and their participation in the Colorado Indigent Care Program (CICP).

Cash Fund administrative expenses have grown rapidly. In FY 2010-11, they were \$5.7 million. By FY 2014-15 they were \$38.3 million. They pay for 65 full-time equivalent administrators in HCPF.

CAN YOU FIND THE FEE?

Regional Medical Center Invoice table with columns: DATE, SERVICE DESCRIPTION, CODE, CHARGE. Includes a magnifying glass over the 'Emergency Room' row.

The Act stipulates that "a hospital shall not include any amount of the provider fee as a separate line item in its billing statements."

SOME HOSPITALS WIN, SOME HOSPITALS LOSE

Provider charges paid by different patients in the same hospital receiving exactly the same services can differ by hundreds of dollars. Colorado's "redistributive waiver" from the Centers for Medicaid and Medicare Services requires that supplemental payments funded by the provider charge be structured to ensure that the state does not fully reimburse all individual hospitals for the provider charges they remit. Cash Fund payments to hospitals are based on Medicaid discharges, hospital classification, and hospital costs, not on the charges paid.

As a result, some hospitals, and by extension their patients, pay much more in provider charges than they receive in Cash Fund supplemental payments. In the last 3 years, Centura Health's Littleton hospital paid \$5 million more in charges than it received in supplemental payments. Health One's Sky Ridge Hospital paid \$8 to \$10 million more than it received. In FY 2015-16, Denver Health will pay \$22.9 million in charges and receive \$119.1 million in supplemental payments, about 5 times as much as it pays. The University of Colorado Hospital will pay \$43.8 million in charges and receive \$70.1 million. Weisbrod Memorial County Hospital in Eads is expected to receive 24 times as much as it pays. Haxton hospital will receive 15 times as much, Yuma District Hospital 5 times as much, and Aspen Valley Hospital 3.4 times as much. Some hospitals receive supplemental payments without paying any charges at all.

Assertions that supplemental Medicaid payments from the provider charge reduce hospital shifting of Medicaid costs to other payers are not supported by existing evidence. Instead, it suggests that hospitals respond to low Medicaid payment by providing lower quality care, reducing capital expenditures, and offering less treatment. It makes little sense to suppose that revenue maximizing hospitals capable of dictating prices to private payers will lower their charges simply because they receive higher supplemental payments for treating a larger group of Medicaid patients.

PROVIDER FEE CASH REDUCES LEGISLATIVE OVERSIGHT OF THE MEDICAID PROGRAM

Supplemental Medicaid payments funded by the provider charge put more Medicaid funding on autopilot, reducing legislative oversight. This protects Medicaid, which consumes more than 25 percent of state revenues, from competing for funding on an equal footing with other government spending priorities.

As an enterprise fund, the Cash Fund would be an autonomous special interest group devoted to extracting more money from the private sector for the benefit of Medicaid bureaucrats, Medicaid client hospitals, and Medicaid contractors by applying charges to hospital bills that raise health care costs and extract further funds from federal taxpayers and private payers. There is nothing to stop the managers of such a fund from manipulating payments to expand their power over both public and private hospitals. If history is any guide, that manipulation will not benefit the people who pay the provider charge.

THE PROVIDER CHARGE IS A TAX MASQUERADING AS A FEE

The Colorado Constitution requires a popular vote on any new state tax. The provider charge was passed at a time when it was clear that Colorado's economically stressed voters would not approve a new tax. Calling the provider charge a fee rather than a tax allowed the legislature to evade its constitutional duty. Laws passed after 2009 turned Medicaid expansions that were supposed to be limited by the funds collected by the provider charge into state entitlements.

In order to consider the provider charge a fee, one would have to argue, among other things, that expanding the Medicaid program and increasing the amount that it pays for services is not a general expense of government, even when that program consumes more than 25 percent of state revenues. And that Disproportionate Share Hospital payments and CICP costs that were formerly considered general government expenses and appropriated from the General Fund are no longer general expenses of government simply because they are now paid for by something called a fee.

This Issue Brief is excerpted from a longer Issue Paper on the Hospital Provider Fee Cash Fund, which can be found here: <https://www.i2i.org/the-hospital-provider-fee-fund/>