



**INDEPENDENCE**  
INSTITUTE.ORG

## **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

**by Linda Gorman**

IP-2-2016 | April 2016

# Introduction

---

In 2009, the Colorado General Assembly passed the Colorado Health Care Affordability Act of 2009, HB 09-1293. The Act imposed an up to 5.5 percent charge on hospital bills. It created the Hospital Provider Fee Cash Fund<sup>1</sup> and the Hospital Provider Fee Oversight and Advisory Board within the Department of Health Care Policy and Financing (HCPF). The Colorado Constitution requires a popular vote on any new tax under the Taxpayer Bill of Rights (TABOR). The Great Recession hit its lowest point in June, 2009. At the time, it was clear to observers that Colorado's economically stressed voters would not approve a new tax for Medicaid or anything else.

By calling the provider charge a fee rather than a tax, the legislature was able to collect and use the revenue from the provider charge without asking permission from the voters.

There is little doubt that raising revenue was the main purpose of the Act. Colorado statute says that if federal [Medicaid] matching funds are no longer available, HCPF shall "cease collecting the provider fee and shall repay to the hospitals any moneys received by the fund that are not subject to federal matching funds."<sup>2</sup> The matching funds derive from the fact that the federal government pays at least half of every Colorado Medicaid medical bill. If each bill is increased by adding a provider charge, the federal government pays half of the bill plus half of the additional charge. In short, the Colorado Hospital Provider Fee Cash Fund is devoted to inflating hospital bills in order to drain more money from the US Treasury.

Although official discussions of hospital reimbursements treat hospitals as a monolithic block and stress that provider

fees are returned to the hospitals, some hospitals have endured millions of dollars in net losses each year. HealthOne's Sky Ridge Hospital, for example, is expected to lose \$9.9 million in FY 2015-16. Academic studies show that hospitals adjust to lower revenues by reducing the intensity of the treatment that they provide and that this can negatively affect patient outcomes. Patients hospitalized in those hospitals get less care than they pay for. Patients hospitalized in hospitals that are big net gainers from the Hospital Provider Fee Cash Fund payments, hospitals like Denver Health (\$119.2 million from the Fund with a net gain after fees paid of \$96.2 million), the University of Colorado Hospital (\$70.1 million with a net gain of \$26.3 million), Memorial Hospital (\$65.7 million with a net gain of \$31.9 million), and Children's Hospital (\$52 million with a net gain of \$32.6 million), get more care than they pay for. Using the Fund to make supplemental Medicaid payments based on hospital costs is not good policy. It also makes Medicaid reimbursements look lower than they really are, disguising the fact that some hospitals make money on Medicaid patients.

In addition to supplemental payments, the Hospital Provider Fee Cash Fund includes a \$61.4 million Quality Indicator program. It is designed as a pay for performance program based on quality metrics chosen by the Oversight Board. Hospitals can get additional payments from the Fund if they meet the Program's targets. The measures chosen appear aimed at controlling Medicaid program expenditures. The Quality Initiative Program report gives some support for this viewpoint by explaining that measures change over time because "the needs of Medicaid clients change over time."<sup>3</sup>

In order to consider the hospital provider charge a fee, one would have to argue

---

By calling the provider charge a fee rather than a tax, the legislature was able to collect and use the revenue from the provider charge without asking permission from the voters.

---

that expanding the Medicaid program and increasing the amount that it pays for services is not a general expense of government, even when a program consumes more than 25 percent of state revenues. One would have to argue that Disproportionate Share Hospital payments and Colorado Indigent Care Program costs, expenses that were formerly considered part of general government expenses and appropriated from the General Fund, are no longer a general expense of government simply because they are now paid for by something called a fee. One would also have to argue that using the provider charge to supplement the General Fund and manipulate revenues in order to trigger road spending and avoid TABOR refunds do not serve the general purposes of government.

This Issue Paper discusses:

- How the provider charge funds are used in an effort to determine whether it is a fee or a tax.
- Describes why the uses of the funds collected probably do not benefit people who pay for their own health insurance.

## The Statute

---

In 2009, the Colorado General Assembly passed the Colorado Health Care Affordability Act of 2009, HB 09-1293. The Act imposed an up to 5.5 percent charge on hospital bills. It created the Hospital Provider Fee Cash Fund<sup>4</sup> and the Hospital Provider Fee Oversight and Advisory Board within the Department of Health Care Policy and Financing (HCPF). Along with a number of other payments, Disproportionate Share Hospital funding (DSH) and Colorado Indigent Care Program (CICP) funding are now appropriated from the Provider Fee Cash

- Shows that providing Medicaid with a dedicated revenue stream from the Hospital Provider Fee Cash Fund likely reduces legislative scrutiny of the Medicaid program by protecting the program from competition for funds by other programs.
- Explains how Medicaid supplemental payments from the Hospital Provider Fee Cash Fund can substitute for Medicaid reimbursements from the General Fund.
- Describes how the existence of Hospital Provider Fee Cash Fund revenues allowed state government to first claim that Medicaid expansions should be supported as they were limited by the revenues raised by the Fund, only to later change them into entitlements funded by the General Fund.
- Describes how the executive branch of state government has sought to manipulate Hospital Provider Fee Cash Fund revenues to affect General Fund appropriations.

Fund.<sup>5</sup> They were formerly appropriated from the General Fund.<sup>6</sup>

Excess Hospital Provider Fee Cash Fund funds do not become part of the General Fund. Collection of the provider charge is contingent on the continuation of federal Medicaid matching funds. Colorado statute says that if federal matching funds are no longer available, HCPF shall “cease collecting the provider fee and shall repay to the hospitals any moneys received by the fund that are not subject to federal matching funds.”<sup>7</sup> Payments made by the Fund are made outside of the Colorado

---

In order to consider the hospital provider charge a fee, one would have to argue that expanding the Medicaid program and increasing the amount that it pays for services is not a general expense of government, even when a program consumes more than 25 percent of state revenues.

---

Medicaid Management Information System.

Other states assess similar provider charges on a variety of health care services. The

federal government calls these charges provider taxes. In practical terms, a provider tax is added to a medical bill to inflate the cost of the service and increase the federal matching funds obtained by the state. This makes the Hospital Provider Fee Cash Fund a program devoted to inflating the cost of services provided under Medicaid in order to extract that maximum amount of money from federal taxpayers.

The scheme works because the federal government agrees to pay half or more of every Medicaid medical services bill, including any taxes. When qualified expenses are increased by adding a provider charge, the amount that the federal government matches is higher. The state imposing the charge keeps both the revenues from the charge and the extra matching funds. States can use the new revenues to support their Medicaid program, freeing state funds for other purposes. Some states have made extensive

use of intergovernmental transfers to divert funds from provider charges into other state programs.<sup>8</sup>

Although the Colorado provider charge statute says that provider fund charges must “supplement, not supplant, General Fund appropriations to support hospital reimbursements,” money is fungible.<sup>9</sup> Higher supplemental payments can increase total Medicaid payments without explicit legislative scrutiny, and, as explained below, money from the provider charges has already been used to replace General Fund revenues. Quality incentive payments can be used to shift Medicaid costs to hospitals. They can also be used to pressure medical practitioners to bill and treat in ways favored by Medicaid officials and the special interest groups allied with them.

The statute, and the ways in which the fees are structured, makes it quite clear that they were imposed to increase both Medicaid funding and Medicaid enrollment. The March 30, 2009, Legislative Fiscal Note for the Act said that the “fees” were intended to increase reimbursements to hospitals, increase the number of people covered by medical assistance programs, and pay for administrative costs related to the fee and program expenditures. Reflecting the language in the preamble of the Act, the Fiscal Note referred to the fee income as revenue: “The revenue generated by the hospital provider fee is to supplement current General Fund appropriations to support hospitals. Payments to hospitals must be fully funded before any eligibility expansion.”

Along with giving state government an important source of new revenue, preferentially protecting hospitals from Medicaid reimbursement cuts, and automatically funding supplemental Medicaid payments, the Act reduced legislative scrutiny of the Medicaid program’s costs and benefits. Because it created an automatic fund raising facility and gave HCPF the ability

### Provider Cash Fund Statute Spending Priorities

1. Maximize hospital inpatient and outpatient reimbursements to maximize federal Medicaid matching funds.
2. Make Colorado Indigent Care Program hospital reimbursement 100 percent of hospital cost.
3. Fully fund quality incentive payments before paying for Medicaid expansion.
4. Pay all the administrative costs for the Fund including the cost of hiring additional people, personal services, operating and consulting expenses, and the cost of changes to Medicaid enrollment systems.
5. Expand public eligibility for public medical assistance programs as funds permit for;
  - a. Adults with incomes up to 133 percent of FPL
  - b. Children and pregnant women in CHP+ with incomes to 250 percent of FPL
  - c. Medicaid coverage for disabled if family income is less than 450% FPL and they pay a monthly premium.
  - d. Automatic 12 month eligibility for children who qualify for Medicaid.

to determine the details of fund redistribution, the new funding stream is insulated from competition with the other programs seeking General Fund appropriations. The Act stipulates that General Fund appropriations “for hospital reimbursements shall be maintained at the level of appropriations in the medical services premium line item” and that they may be reduced only if “an index of appropriations to other providers” is reduced by the same amount. In effect, the Act put another large piece of state spending on autopilot.

Subsequent legislation has guaranteed state funding for some of the Medicaid expansions included in the Act. As a practical matter, this changes them from the limited programs funded by provider fund income to entitlement programs that must be supported by state general funds. Had the provider charge not been in effect those Medicaid expansions likely would not have occurred without a popular vote approving the higher taxes necessary to support them.

The Act states that “a hospital shall not include any amount of the provider fee as a separate line item in its billing statements.” Aside from the fact that imposing a new tax without a popular vote violates the Colorado Constitution, there is evidence that people behave differently when taxes are explicit. Research on tax salience suggests that consumers underreact to taxes that are not readily observable. If, as is often argued, many hospital admissions are elective, then people interested in reducing health spending should have welcomed making the tax readily apparent to the patients who initiate the demand for elective services.<sup>10</sup>

The law against making the provider charge visible on hospital bills suggests that the authors of the Act intended to

reduce Medicaid’s funding transparency. If hospitals rather than patients truly do pay the provider charge as supporters contend, there would be no need to list it on hospital bills. Prohibiting any listing of the provider charge as a separate line item suggests that the Act’s authors worried that hospitals might show patients how much their hospital bills were increased by the provider charge, and that Colorado citizens might consider it a new tax.

Officials assert that hospitals pay the provider charge and that the funds collected are immediately returned to hospitals. While this may be true for hospitals as a group, it is not true for all individual hospitals. As Colorado’s provider charge is not uniformly applied to all hospitals, the state had to receive a waiver from the Centers for Medicare and Medicaid Services in order to make its provider charge eligible for matching funds. The terms of the waiver stipulate that the provider charge must be redistributive. This means that the individual hospitals remitting the funds will gain from the provider charge program and some will lose. The people paying the provider charge will gain and lose with them.

---

The law against making the provider charge visible on hospital bills suggests that the authors of the Act intended to reduce Medicaid’s funding transparency.

---

# Where the Money Comes From

Table 1 lists state provider charges in force as of March 17, 2015. Colorado law also allows local governments to impose provider charges to “sustain or increase reimbursements for providing medical care under the state’s medical assistance program and to low income populations.”<sup>12</sup> They are not shown in the table.

Fees are discounted for Managed Care Days, High Volume Colorado Indigent Care Program hospitals, and Critical Access hospitals in order to “offset the impact of the managed care day fees discount and meet the B1/B2 test as required by 42 CFR 433.68(e)(2).”<sup>13</sup>

A critical access hospital is typically a small hospital in a rural area. Critical access hospitals provide limited emergency services and basic acute care. Some have physicians on site. The rest are staffed by physician extenders and nurses with advanced training in emergency care. On-call services must be available within 60 minutes. Critical access hospitals meeting federal guidelines are eligible for cost plus payments from Medicare.<sup>14</sup>

The B1/B2 test ensures that the change in the percentage of provider charges collected by a specific hospital with a

specific number of Medicaid inpatient days is roughly the same under a state’s proposed provider charge scheme as it would be when a uniform provider charge is applied to all hospitals. Passing the B1/B2 test it is a requirement for a federal waiver allowing matching funds for provider charges that are not uniformly applied.

As long as it meets the waiver requirements, HCPCF may exempt hospitals from the provider charge, change the way in which payments from the Hospital Provider Fee Cash Fund are allocated, and change hospital reporting requirements. At present, provider charges vary depending upon a patient’s health coverage and the type of hospital he is in. Inpatient provider charges are a daily charge that do not depend on the value of the services a patient receives while in the hospital. Two people getting exactly the same inpatient services at the same hospital at the same time can pay different fees if one is a self-pay patient and the other has managed care coverage. A patient would pay the least if he had managed care coverage and was hospitalized in a critical access hospital. He would pay the most if he paid cash for a procedure in a privately owned hospital.

---

Two people getting exactly the same inpatient services at the same hospital at the same time can pay different fees if one is a self-pay patient and the other has managed care coverage.

---

Inpatient Managed Care Day	\$76.16
Inpatient Managed Care Day 30% Medicaid & CICP*	\$39.76
Inpatient Managed Care Day Critical Access Hospital	\$30.46
Inpatient non-Managed Care Day	\$340.49
Inpatient non-Managed Care Day, 30% Medicaid & CICP	\$177.77
Inpatient non-Managed Care Day Critical Access	\$136.96
Outpatient fee, percentage of total bill	1.9477%
Outpatient fee, percentage of total bill, Medicaid & CICP	1.9313%
Free-standing psychiatric, long-term care, and rehabilitation hospitals	No fee
*CICP is the Colorado Indigent Care Program. The provider charge structure is limited by a federal rules. It may not exceed 6 percent of net patient revenues without special dispensation. The rule was 5.5 percent from January 1, 2008, to September 30, 2011. The charge must be structured so that some providers “will receive proportionately less in reimbursement compared to their assessed amount.” Source: Hospital Provider Fee Oversight and Advisory Board, Colorado Department of Health Care Policy and Finance. <i>Colorado Health Care Affordability Act, Annual Report</i> , January 15, 2016.	

Outpatient charges depend on the total charges for services rendered. There are two different provider charge rates. The rate applied depends on types of patients treated by the facility a patient finds himself in, not on the value of the services rendered.

In addition to provider charges, Hospital Provider Fee Cash Fund amounts are appropriated for the Disproportionate Share Hospital (DSH) program and the Colorado Indigent Care Program (CICP). Both programs were in effect before the Act passed. The DSH program is a federal program that provides supplemental payments to hospitals that treat larger numbers of Medicaid patients. The CICP program is a Colorado program that provides means tested state subsidized pricing for medical care needed by acutely ill people.

Payments for the CICP and DSH predated the establishment of the Hospital Provider Fee Cash Fund. The Oversight Board calculates that the state would have

allocated \$162.9 million for CICP prior to the creation of the Fund. It estimates that the net increase in hospital payments from the Fund is approximately \$334.9 million.<sup>15</sup>

Table 2 is reproduced from the 2016 Hospital Provider Fee Oversight and Advisory Board Annual Report.<sup>16</sup> Although it is an unconventional presentation of fund inflows and outflows, it does suggest that the provider charge collected over \$688 million dollars from Colorado hospitals on a Federal Fiscal Year basis, October 1, 2014, to September 30, 2015.

Table 3, also from the 2016 report, shows how the total funds collected from the hospital provider charge were expended for State Fiscal Year 2014-15, July 1, 2014, through June 30, 2015.<sup>17</sup> More than half of the expenditures, over \$1.4 billion, support Medicaid expansion. About a third supports the general Medicaid program by using supplemental payments to increase total reimbursement.

---

There are two different [outpatient] provider charge rates. The rate applied depends on types of patients treated by the facility a patient finds himself in, not on the value of the services rendered.

---

<b>TABLE 2</b>	
<b>2014-15 Hospital Provider Fees and Payments</b>	
Inpatient Fee	\$364,306,000
Outpatient Fee	\$324,142,000
<b>Total Hospital Provider Fees</b>	<b>\$688,448,000</b>
Inpatient Hospital Reimbursement	\$606,802,000
Outpatient Hospital Reimbursement	\$207,647,000
Uncompensated Care Payment	\$115,400,000
Disproportionate Share Hospital Payment	\$194,902,000
Hospital Quality Incentive Payment	\$61,449,000
<b>Total Supplemental Hospital Payments</b>	<b>\$1,186,200,000</b>

<b>TABLE 3</b>	
<b>State Fiscal Year 2014-15 Hospital Provider Fee Expenditures (Total Funds)</b>	
Supplemental Hospital Payments	\$897,431,000
Department Administration	\$38,289,000
Medicaid Expansion Populations	\$1,452,500,000
Offset revenue loss to certain public hospitals	\$15,700,000
<b>Total Expenditures</b>	<b>\$2,403,899,000</b>

# Where the Money Goes

Figure 1, copied from a Joint Budget Committee (JBC) Staff Briefing in 2015, shows Hospital Provider Fee Cash Fund funds have been used since the Fund's inception. In an effort to bolster state spending in a time of declining tax revenues, revenue from the Fund were transferred to the General Fund from FY 2009-10 through FY 2012-13. This transfer is shown by the top rectangle on the first 4 bars. General Fund relief ended in FY 2013-14.

The JBC estimates that 75 to 85 percent of the Hospital Provider Fee Cash Fund has been used for supplemental payments to hospitals. The first two kinds of supplemental payments are transfers directly from the Fund and transfers that are run through the Fund's Quality Incentive Payment Program. These are combined in the lowest rectangle on each of the bars. They have been steady at roughly \$300 million since FY 2011-12 but are projected to increase substantially as a result of Medicaid expansion.

The rectangles that are second from the bottom of each bar show supplemental payments from the CICP. The Staff

Briefing document explains that even though the Fund payments and the CICP payments are made by the Fund, they are shown separately because they are appropriated under different statutes and are different line items in the state budget.

The cost of administering the Hospital Provider Fee Cash Fund is shown by the 4th rectangle from the bottom of each bar. Administrative expenses have grown rapidly. In FY 2010-11, administrative expenses were just \$5.7 million.<sup>19</sup> In FY 2014-15 administrative expenses were \$38.3 million. They paid for 65 full-time equivalent administrators in HCPF and more than \$7 million in technology contracts.<sup>20</sup> The cost of program administration are projected to increase substantially in the years to come.

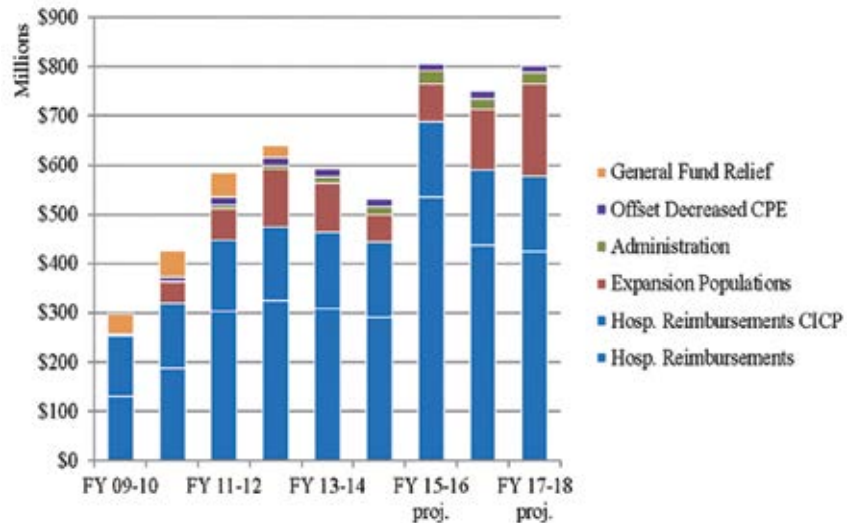
Under federal rules, the introduction of the provider charge reduced the certified public expenditures that certain hospitals claimed, reducing revenues. In order to make those hospitals whole, they are paid \$15.7 million a year from the Hospital Provider Fee Cash Fund. This amount is represented by the 5th rectangle from the bottom of each bar. Payments from

---

In an effort to bolster state spending in a time of declining tax revenues, funds from the Hospital Provider Fee Cash Fund were transferred to the General Fund from FY 2009-10

---

**FIGURE 1**





the Fund substitute for payments from the General Fund. According to the JBC, “the General Assembly documented expenditure by local governments to support public hospitals and used these as certified public expenditures (CPE) to match federal funds for Medicaid reimbursement in lieu of using the General Fund.”<sup>21</sup>

By FY 2017-18, slightly more than half of all Hospital Provider Fee Cash Fund expenditures are slated to be “new” hospital reimbursements. Although Medicaid expansion under federal Patient Protection and Affordable Care Act of 2010 (Obamacare) and individual insurance mandate were projected to reduce the need for CFCP payments, the projections assume a steady increase rather than a decrease. This may be a reasonable assumption if falling need is counterbalanced by medical services expenditure growth or a growing population.

If Hospital Provider Fee Cash Funds are insufficient to support the Medicaid expansions named in the statute, the Advisory Board must recommend reductions in medical benefits or eligibility. The reductions must be approved by the JBC and the Colorado Medical Services Board. A JBC analysis holds that the Fund pays for the state share of those who were “newly eligible” for Medicaid under Obamacare. This includes able-bodied adults without dependent children with incomes up to 138 percent of the Federal Poverty Level and caretakers of children with incomes from 69 percent to 138 percent of the Federal Poverty Level. In FY 2016-17, the state projects that providing Medicaid coverage for those “expansion populations” will increase state Medicaid expenditures by \$144.2 million. If the federal government adjusts the expansion population matching rate

downwards, state Medicaid expenditures could be considerably higher.

The statute, and the ways in which the provider charges are structured, makes it quite clear that they were imposed to raise revenues for Medicaid funding and Medicaid enrollment. The March 30, 2009, Legislative Fiscal Note for the Act said that the “fees” were intended to increase reimbursements to hospitals, increase the number of people covered by medical assistance programs, and pay for administrative costs related to the fee and program expenditures. Reflecting the language in the preamble of the Act, the Fiscal Note referred to the fee income as revenue: “The revenue generated by the hospital provider fee is to supplement current General Fund appropriations to support hospitals. Payments to hospitals must be fully funded before any eligibility expansion.”

The same JBC analysis also describes how the state executive branch moves provider fee funds between fiscal years, and planned to meet specific spending goals by Hospital Provider Fee Cash Fund funding. Under revenue forecasts made in September 2015, reducing state tax revenues by \$100 million would have kept the state under the TABOR refund limit. As long as state revenues were under the limit, automatic appropriations of \$108.6 million for roads and \$27.2 million for capital construction would have occurred from the General Fund.<sup>22</sup> Without the automatic transfers, the Governor’s Office would have had to ask the General Assembly for more funding for roads. Instead, it planned to keep the automatic appropriations in place by asking HCPF to reduce revenues to the Fund by \$100 million.<sup>23</sup>

The large year to year variations in the calculations for fee redistribution make it unlikely that fees are redistributed in ways that actually defray specific recurring

---

The statute, and the ways in which the provider charges are structured, makes it quite clear that they were imposed to raise revenues for Medicaid funding and Medicaid enrollment

---

costs. Redistribution characteristics are unpredictable enough that when the JBC asked HCPF to estimate the effect of the Governor's proposed reimbursement reduction on each hospital, it responded that it could not do this because "the new FFY 2015-16 model is under development...Because of these multiple variables, the distribution of net reimbursement to individual hospitals in FFY 2015-16 may vary greatly compared to the distribution of net reimbursement in FY 2014-15."<sup>24</sup>

In 2014, the US Department of Health and Human Services found that Colorado's supplemental Medicaid payments to hospitals and nursing homes had exceeded federal limits by more than \$5 million.<sup>25</sup> In FY2013-14, HCPF reported that the Hospital Provider Fee Cash Fund:

...intentionally paid less than the maximum allowable under the federal limits. The lower payments were negotiated to be less than the federal limits based on increased scrutiny from the Centers for Medicare and Medicaid Services and an attempt to prevent the need for future audit adjustments. In FY 2015-16 expenditures are expected to increase dramatically due to the Medicaid expansion increasing the federal limits on booster payments.<sup>26</sup>

In the Hospital Provider Fee Cash Fund's early years, state government also collected more provider charges than needed to fund the program. The 2012 State Auditor's report noted that the Fund collected "significantly more in hospital provider fees than it needed to fund the Program during the first two Model years. The majority of the overcollections in the first two years are attributable to overestimation

of the amount of provider fees needed to fund the expansion populations."<sup>27</sup>

Although the Medicaid expansions supported by the Hospital Provider Fee Cash Fund were supposed to be entirely dependent on its support, subsequent legislation has turned them into entitlements that are presumably eligible for funding from the General Fund. According to the JBC:

Senate Bill 13-200 included provisions protecting the Medicaid expansion populations required to receive the ACA's [Obamacare] enhanced federal match from reductions due to insufficient hospital provider fee revenues... The remaining eligibility criteria and benefits that are financed from the Hospital Provider Fee that could potentially be reduced are the disabled buy-in program, services for pregnant adults on CHP+, and continuous eligibility for children.<sup>28</sup>

CHP+ eligibility for pregnant adults, otherwise known as pregnant women, is an optional program for women with household incomes under 260% of the Federal Poverty Level (FPL), roughly \$30,900 for a single person and \$63,180 for a family of 4 in 2016. The enrollment fee is \$50 a year. Prenatal care is free, physician copays are \$10 while in the hospital, and hospital copays are \$50. CHP+ limits out-of-pocket payments to 5 percent of household income.

Whether it makes sense to heavily subsidize pregnant women in times of budgetary stringency is a political decision. Women eligible for CHP+ are also eligible for federally subsidized health insurance policies. The major difference is that the federal policies require premium and cost sharing payments that cost more than

---

The large year to year variations in the calculations for fee redistribution make it unlikely that fees are redistributed in ways that actually defray specific recurring costs.

---

CHP+. An individual with an income of \$23,760, roughly 200 percent of the FPL, would pay a \$250 deductible and have a maximum out-of-pocket limit of \$2,000. Premiums would be capped at 6.41 percent of modified adjusted gross income. Continuous eligibility for children means that anyone under the age of 19 who qualifies for Medicaid or CHP+ on the basis of income will continue to be eligible for that program even if family

income increases over the next year.<sup>29</sup> The Hospital Provider Fee Fund was substituted for General Fund payments in 2015, resulting in a \$21 million saving for the General Fund. According to the FY2015-16 Joint Budget Committee Long Bill Narrative, this reduces “the amount of Hospital Provider Fee available for booster payments, thereby reducing the federal funds.”<sup>30</sup>

## Understanding the interaction between General Fund Medicaid payments and the Hospital Provider Fee Cash Fund

Fully understanding how the Hospital Provider Fee Cash Fund defrays general government expenses requires understanding how federal matching payments support Colorado’s Medicaid program. State officials like to remind people that Medicaid is the state’s largest health insurer. This is a semantic mistake because the state budget simply expands to provide all of the health care necessary, but the state does not take on risk in exchange for a premium payment. Still, there is no doubt that Medicaid is on course to becoming the most expensive program in Colorado state government.

In January, 2016, an estimated 1.3 million people were enrolled in Colorado Medicaid. Its FY 2015-16 appropriation was almost \$6.6 billion. It will spend an estimated 26 percent of General Fund revenues. In FY 2015-16 it will receive 60 percent of its funding from the federal government, 28 percent of its funding from the General Fund, and almost 12 percent of its budget from cash funds. It

pays for 43 percent of Colorado births.<sup>31</sup> Although medicine has changed since 1965, the basic structure of Medicaid has remained fixed and there is little doubt that there are less expensive and more effective ways to provide needed health care for those who are too poor or too ill to provide it for themselves

The Medicaid program pays for services to its clients in two distinct ways. Providers receive regular claims-based payments, generally called reimbursements, for specific medical services provided to specific Medicaid recipients at specific rates set by Colorado Medicaid. These payments include per member payments to managed care providers who promise to provide all medical care for a Medicaid client for a specific monthly fee.

Some medical providers receive supplemental payments in addition to reimbursements for services rendered. Labeled quality incentive payments, payment bumps, boosters, adjustments,

---

Although medicine has changed since 1965, the basic structure of Medicaid has remained fixed and there is little doubt that there are less expensive and more effective ways to provide needed health care for those who are too poor or too ill to provide it for themselves

---

and grants, the supplemental payments add substantially to total reimbursement. In FY 2014-15, Colorado Medicaid paid hospitals \$1,202 million for acute inpatient and outpatient services.<sup>32</sup> Additional supplemental payments from the Hospital Provider Fee Cash Fund of \$335 million were the equivalent of a 28 percent increase in reimbursements for services rendered.

States have long sought to make Medicaid look frugal by setting its claims-based reimbursement rates at artificially low levels and making supplemental payments

difficult to track. This shifts some costs from the state to patients and medical services providers through reductions in the quality and intensity of care, long waits, and lower returns. Low reimbursement strategies are limited by the fact that most states do not yet compel providers to participate in Medicaid. Rates that are too low make providers less likely to offer services to the Medicaid program. Low reimbursement rates without supplemental payments may also bankrupt hospitals in areas where most patients are uninsured or are covered by Medicaid or Medicare.

## The Role of Supplemental Payments

---

---

In essence, the DSH program rewarded state governments for having a policy of underpaying for medical services for Medicaid clients.

---

In order to address the effect of states' artificially low Medicaid reimbursement rates on hospitals, the federal government instituted the Disproportionate Share Hospital program (DSH) in 1981.<sup>33</sup> Designed to supplement claims-based reimbursements, DSH payments were aimed at hospitals judged unable to "shift," or make up, low Medicaid payments by over-charging private patients. To help these hospitals, the federal government required states to make DSH payments to hospitals that had large fractions of Medicaid or uninsured patients in their caseload. In return for making those payments, the federal government agreed to match them with federal funds. In essence, the DSH program rewarded state governments for having a policy of underpaying for medical services for Medicaid clients.<sup>34</sup>

States immediately began hatching financing schemes to inflate Medicaid charges in order to maximize their federal DSH payments. An early scheme directed DSH funds to hospitals or other providers who made "donations" or paid taxes

designed to inflate Medicaid charges. The states returned the donations and taxes to providers and kept the federal matching funds. When hospitals qualified for DSH funds were state owned, some states simply increased Medicaid charges, paid them, took the higher federal Medicaid matching funds, and then shifted the big state payments for services out of the hospital budget using intergovernmental transfers.

When DSH abuse was uncovered, the federal government proposed reforms to limit it. As the states found new ways to game the matching fund system, the federal government added more layers of regulation.<sup>35</sup> Early reforms limited provider taxes to 25 percent of a state's share of Medicaid and capped state DSH payments at their 1992 levels. At present, the federal government sets a limit on the maximum matching fund payments it will make in a variety of categories. Table 4 shows the upper payment guidelines for Colorado in federal fiscal year 2015-16. The Upper Payment Limit (UPL) is based on the amount that Medicare would likely pay for similar services. States calculate upper

TABLE 4 Hospital Upper Payment Limits for Colorado Federal Fiscal Year 2015-16		
Hospital type	Inpatient	Outpatient
State government hospital	\$116,172,753	\$63,680,060
Non-state government hospitals	\$297,874,352	\$230,661,260
Private hospitals	\$1,023,184,341	\$660,868,309
Total	\$1,437,231,446	\$955,209,629

*Source: Colorado Department of Health Care Policy and Financing, Special Financing Division.*

payment limits using federal guidelines. Federal law requires that states receive federal approval for their plan to use DSH funds, and federal law caps both the amount of DSH funding a state can receive and the amount that can be paid to a single hospital.

In FY 2014-15 Colorado received \$100,226,893 in federal funds from DSH and made payments to hospitals totaling \$194.9 million.<sup>36</sup> In order receive DSH payments a Colorado hospital must:

1. Participate in the Colorado Indigent Care Program and have at least two obstetricians on staff, or

2. Have a “Medicaid Inpatient Utilization rate equal to or greater than the mean plus one standard deviation” of all Medicaid Inpatient Utilization Rates for Colorado hospitals and have two obstetricians on staff.<sup>37</sup>

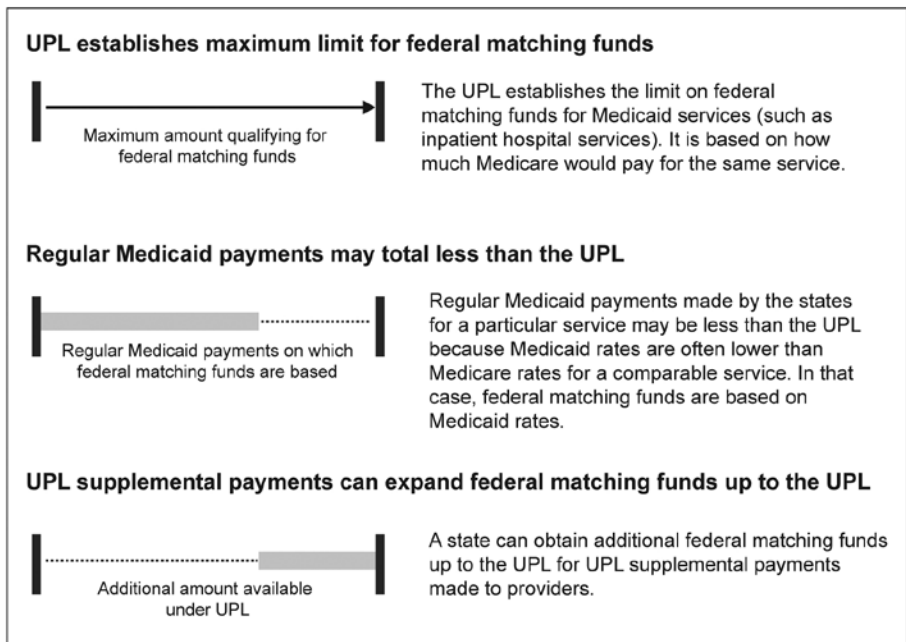
States that would not normally spend enough on Medicaid to reach their UPL have developed supplemental payment programs to inflate payments for medical services to their UPL.<sup>38</sup> Figure 2, copied from a 2015 Government Accountability Office (GAO) report, illustrates how UPL supplemental payment programs work.<sup>39</sup>

---

States that would not normally spend enough on Medicaid to reach their [Upper Payment Limit] UPL have developed supplemental payment programs to inflate payments for medical services to their UPL.

---

**FIGURE 2**



Source: GAO. | GAO-15-322

Note: The UPL applies to regular Medicaid payments and UPL supplemental payments and does not include Disproportionate Share Hospitals (DSH) supplemental payments. DSH supplemental payments are made to cover the hospitals' uncompensated care costs for inpatient and outpatient hospital services provided to Medicaid and uninsured patients and have separate payment limits.

States use provider taxes and fees to generate some of their supplemental payments to providers. The federal government defines provider taxes as “a health care-related fee, assessment, or other mandatory payment for which at least 85 percent of the burden of the tax revenues falls on health care providers.”<sup>40</sup> Unless states prove that their provider taxes are “generally redistributive,” provider taxes must apply to all providers within a specified class and be the same for all providers in a specified category. States cannot guarantee that providers receive their money back after paying provider taxes. Federal law prohibits provider tax revenue from exceeding 25 percent of the state share of Medicaid expenditures,<sup>41</sup> and “federal regulations prohibit payments by a state Medicaid agency to providers for services rendered under contract with a managed care organization.”<sup>42</sup>

1. Hospital inpatient payments = (Estimated Medicaid Discharges) x (Medicaid base rate) x (hospital percentage adjustment factor)
2. Outpatient hospital payments = (Medicaid outpatient billed costs adjusted for utilization and inflation) x (hospital percentage adjustment factor)
3. Uncompensated care payment, fewer than 25 beds = (Percent of total beds for all qualified hospitals with fewer than 25 beds) x (\$33,500,000)
4. Uncompensated care payment, greater than 25 beds = (Percent of total uncompensated care costs for qualified hospitals) x (\$81,980,176).<sup>44</sup>

Note that actual provider charges never enter into the formulas. The hospital percentage adjustment factors in the equations above are factors that are greater than 100 percent for non-state government rural hospitals (103 percent), private rural hospitals (132.03 percent), private non-Metro Denver Hospitals (119.37 percent), and private hospitals with level 3B or 3C neonatal intensive care units (128.03 percent). Psychiatric hospitals are not qualified for payments as federal regulations for matching funds under a redistributive waiver require that certain categories of hospitals be excluded.

By making definitions sufficiently narrow, payments can be manipulated to ensure that only specific hospitals qualify. Neonatal intensive care hospitals must be level 3B or 3C. Colorado has only a handful of them, mostly regional referral centers in Grand Junction, Colorado Springs, and Denver. While subsidizing facilities to care for severely ill babies before and after birth may be a fine use for public money, a more transparent subsidy process would aid the legislature in evaluating those subsidies against other uses for government funds. Non-Metro Denver hospitals are another narrowly defined category. They are hospitals

---

The Hospital Provider Fee Cash Fund provided a new source of funding during a period in which state government was heavily invested in Medicaid expansion and the General Assembly and the Executive Branch were controlled by the Democratic Party.

---

Federal rules require that at least 40 percent of nonfederal Medicaid spending be derived from state funds including “state general funds, health care provider taxes imposed by the state, provider donations received by the state, and inter-agency funds from non-Medicaid state agencies.”<sup>43</sup> The federal rules mean that states must find new sources of funding in order to expand Medicaid. The Hospital Provider Fee Cash Fund provided a new source of funding during a period in which state government was heavily invested in Medicaid expansion and the General Assembly and the Executive Branch were controlled by the Democratic Party.

The explanation of how the Hospital Provider Fee Cash Fund supplemental payments are calculated makes it clear that their amount is unrelated to the services provided to the people or hospitals who pay the fee. According to the 2016 Annual Report from the Provider Fee Oversight and Advisory Board, hospital supplemental payments are calculated as follows:

“located in a Metropolitan Statistical Area (MSA) outside of the Denver-Aurora Combined Statistical Area (CSA) with a population between 125,000 and 325,000.”<sup>45</sup> According to US Census estimates of Metropolitan Statistical Area populations in 2015, only privately owned

hospitals in Boulder, Grand Junction, and Greeley would be eligible for subsidy in this category.

## **Supplemental Payments, the General Fund, and the Problems with Cost Based Reimbursement**

---

The Medicaid program reimburses hospitals for their costs in both its claims based reimbursement and its supplemental payments. It also pays hospitals based on their Medicaid caseloads and their critical access characteristics. In Colorado, Medicaid claims-based reimbursements take hospital cost into account. So do Upper Payment Limits for 2015-16. They rely on 2013 hospital cost reports filed with the Centers for Medicare and Medicaid Services (CMS Form 2552-10) adjusted for “for utilization and inflation” in order to arrive at estimated costs for 2016.

A basic problem is that hospitals paid on the basis of their costs have little incentive to minimize them. A substantial body of academic work suggests that hospitals adjust the care that they provide to the level of payment that they get. As one might expect, for-profit hospitals appear to pay closer attention to matching their revenues and operating costs than not-for-profit hospitals and those run by government. Using Medicare hospital cost reports from 1996 to 2009, White and Wu found that:

For-profit hospitals were generally more affected by, and more responsive to, reductions in Medicare revenues than not-for-profit hospitals. For-profits reduced operating expenses more

aggressively than not-for-profits but faced even larger reductions in revenues, suggesting a fairly major contraction in the intensity of services provided. The net result for for-profits was a reduction in profits roughly equal to the reduction in Medicare revenues. Government hospitals appear to be generally less responsive to the loss of Medicare revenues in their staffing levels and personnel expenses.<sup>46</sup>

Non-government hospitals made an estimated three-fifths of their adjustment to lower Medicare revenues by reducing personnel costs. The remainder came from other reductions including delaying or forgoing capital improvements. Given that government hospitals made smaller adjustments in staffing and personnel expenses, it is reasonable to ask whether they made larger cuts in other areas like maintenance of plant and equipment. Another question is whether for-profit hospitals were more responsive because they had more efficient operations than not-for-profit hospitals.

Looking at total Medicaid payments by combining supplemental payments with claims-based reimbursements can produce some surprising totals. The US Government Accountability Office

---

A basic problem is that hospitals paid on the basis of their costs have little incentive to minimize them.

---

(GAO) examined 2011 payments to seven hospitals in Illinois and nine in New York from the three largest ownership groups. It chose the hospitals from the groups that had the highest daily inpatient payments. Six of the seven hospitals in Illinois and four of the nine hospitals in New York received Medicaid payments that were higher than the Medicaid costs they reported to the state. Two local government hospitals received payments “exceeding their costs by nearly \$400 million.”<sup>47</sup>

According to the GAO, when total payments adjusted for differences in patient health were divided by patient days in Illinois and New York, some hospitals enjoyed total Medicaid reimbursement that exceeded their total cost of providing services to all patients:

When comparing the Medicaid inpatient payments—regular and UPL supplemental payments—to the costs of providing those services, estimated using cost reports prepared by hospitals, for hospitals with the highest daily payments, we found that six of the seven selected hospitals had total Medicaid inpatient payments that exceeded those hospitals’ total costs of providing these services.[footnote from original

report omitted] The three local government hospitals and three private hospitals had Medicaid inpatient hospital payments that exceeded costs, ranging from about \$273,000 to about \$18 million over costs. The one state hospital had payments that were \$4 million less than costs, with \$124 million in payments compared to \$128 million in costs.<sup>48</sup>

It is important that hospitals profit from treating Medicaid patients. Hospitals must charge more than they spend on providing services in order to maintain their facilities, improve their services, and plan for the future. The GAO results simply show that dividing Medicaid payments into claims-based reimbursements and supplemental payments makes it extremely difficult to evaluate whether Medicaid payments are too small, too large, or just right, and that total Medicaid reimbursement may be much more robust than recipients would have the public, and its representatives, believe.

Table 5 shows Colorado’s Aspen Valley Hospital District’s net patient service revenue as reported in its 2014 audited financial statement.<sup>49</sup> The parentheses around the Medicaid contractual adjustments reported in the audited

---

The GAO results simply show that dividing Medicaid payments into claims-based reimbursements and supplemental payments makes it extremely difficult to evaluate whether Medicaid payments are too small, too large, or just right, and that total Medicaid reimbursement may be much more robust than recipients would have the public, and its representatives, believe.

---

**TABLE 5  
Aspen Valley Hospital District  
Net Patient Service Revenue  
Audited Financial Statement, 2014**

	2013	2014
Gross patient service revenue	\$91,158,048	\$81,815,079
Less		
Medicare contractual adjustment	\$10,997,250	\$7,130,043
Medicaid contractual adjustments	(\$538,075)	\$199,639
Other contractals and adjustments	\$7,984,326	\$7,045,345
Charity Care	\$3,345,549	\$3,024,386
Provision for uncollectable accounts	\$2,041,933	\$2,150,432
Net patient service revenue	\$67,327,065	\$61,905,234



statement would seem to indicate that Medicaid reimbursements for services rendered added more than half a million dollars to its operating income in 2013. In FY 2014-15, it received supplemental payments of \$2.7 million from the Hospital Provider Cash Fund in addition to its contractual reimbursements.

As Eric Kurtz of Colorado's JBC explained, supplemental payments from the Hospital Provider Fee Cash Fund can substitute for General Fund spending. If supplemental payments from the Fund are high, there is less pressure to increase the claims-based reimbursement rates that are appropriated from the General Fund:

However, another way to look at the magnitude of the increase in hospital reimbursements attributable to the Hospital Provider Fee would be to view it as indicative of significant underfunding. The Hospital Provider Fee allows hospitals to be reimbursed up to the upper payment limit. The upper payment limit is essentially what Medicare would have paid for a similar service. So, the Hospital Provider Fee is filling a gap between Medicaid rates and Medicare rates. To the extent that Medicare rates are viewed as the appropriate level of reimbursement, the Hospital Provider Fee is helping to solve chronic underfunding by Medicaid.<sup>50</sup>

Medicaid payments are difficult to manage because no one knows what they should be. Spending huge amounts of time and money to detail hospital cost and reimburse on that basis is unlikely to change this. Costs change constantly as input costs, technology, and patient morbidity change. It is well known

that regulation based on costs does not work well, as costs cannot be objectively determined unless a regulatory commission is "prepared completely to duplicate the role of management itself."<sup>51</sup> A conclusion reached after decades of experience with public utility regulation.

As neither Colorado state government nor the Oversight Board has the managerial capability to duplicate the role of hospital management, it should come as no surprise that the Oversight Board bases its conclusions on "data from the [Colorado Hospital Association] DATABANK and survey data collected by the [Colorado Hospital Association]."<sup>52</sup> CHA DATABANK is an online program available to Colorado Hospital Association members. It is licensed to hospital associations in 14 other states.<sup>53</sup> Although a number of the allocation criteria used for the Hospital Provider Fee Cash Fund supplemental payments rely on official cost reports filed with the federal government, neither the Colorado Hospital Association nor the Oversight Board indicate that the data used to determine public program payments have been audited or been made available for independent verification.

In 2012, the Colorado Office of the State Auditor checked the self-reported hospital data the Oversight Board used in the model used to determine supplemental payments from the Hospital Provider Fee Cash Fund. It found that the data were not always "accurate, consistent, or reliable." The Auditor's Office concluded that "24 (45 percent) of the 53 data points self-reported by hospitals varied by greater than 10 percent from the same data points reported in audited Medicare cost reports. Finally, three (30 percent) of the 10 hospitals in our sample could not provide supporting documentation for one or more of the 221 data points reported in one or more years." One of 10 hospitals in the auditor's sample reported 2,141 Distinct

---

Medicaid payments are difficult to manage because no one knows what they should be.

---

Psychiatric Unit Medicaid patient days “when in fact the hospital did not have a distinct psychiatric unit.” It received \$428,200 in supplemental payments that it was not qualified to receive.<sup>54</sup>

The reporting requirements required to facilitate cost reporting can also impose significant costs on hospitals. For example, the Auditor’s Office reported that at least one hospital could not provide the requested data because its accounting systems did provide data in the form that the state requested. In some cases, hospitals had difficulty understanding what the state was asking for.

The other problem with cost based reimbursement is that it fails to account for customer demand. In general, Colorado’s Medicaid program does not allow people

who use its health services any control over the payments that are made for the services that they use. Clients must accept health services in the form and bundled quantity in which the people who staff the government decide to provide them. An important exception is the Consumer Directed Support Services (CDASS) program, in which Colorado Medicaid clients receive a budget that can be used to hire their own in-home care attendants. As might be expected, CDASS clients spending what they regard as their own money buy different bundles of services, from different suppliers, for different amounts, than do clients dependent on the Medicaid program for the same services.

---

In addition to supplemental payments, the Hospital Provider Fee Cash Fund includes a \$61.4 million Quality Indicator program.

---

## **The Hospital Provider Fee Quality Initiative Program: Questionable Quality Measures, Payments Unrelated to Provider Fees, and Rewarding Hospitals for Clinical Decisions Thought to Lower Medicaid Expenditure**

---

In addition to supplemental payments, the Hospital Provider Fee Cash Fund includes a \$61.4 million Quality Indicator program. It is designed as a pay for performance program based on quality metrics chosen by the Oversight Board. At present, this takes the form of a pay for performance program in which hospitals can get additional supplemental payments by meeting the Program’s targets.

Even assuming that this use of Hospital Provider Fee Cash Fund money does

improve hospital care, placing this activity in the Fund substitutes for General Fund spending. Promoting hospital quality has long been a general government function because Colorado’s General Fund has long paid for extensive licensing and inspection programs to oversee hospitals and the people who work in them. Since developing a Quality Strategy in 2007,<sup>55</sup> HCPF pays for outside audits of Medicaid providers, conducts client satisfaction surveys, and commissions studies of pay for performance simply programs. The

Colorado Department of Public Health and Environment (CDPHE) monitors quality at physical sites where health care is provided, licenses practitioners, and issues an annual report on selected infections acquired when admitted to one of the state's hospitals or other health care facilities. Pay for performance simply extends the quality assurance activities the state oversees. Without the Hospital Provider Fee Cash Fund, the pay for performance program would be funded from money appropriated from the general fund.

Quality measures like those chosen by the Oversight Board are invariably politicized. The problem is measuring the quality of patient outcomes when hospitals treat heterogeneous groups of patients and have limited control over the variables that affect individual response to treatment. Measures that obviously benefit patients are usually adopted voluntarily, obviating the need to pay for performance. As pressure from government to do particular things in particular ways has mounted, the development of quality measures and clinical guidelines has generally moved from informed individual decisions about what is best for an individual patient to political contests between competing interests of payers, practitioners, health policy makers and other third parties.<sup>56</sup>

Though people pushing for the adoption of various quality measures generally claim that their favorite rests on a firm empirical foundation, the measures generally rest on less than convincing evidence. They are ill-suited for evaluating the treatment of individual patients.<sup>57</sup> Few measures are limited to the variables that hospitals and physicians can control, or are subject to change with the comorbidities, genetic profiles, and socioeconomic status of the patients treated. Because different hospitals treat different groups of patients with different problems, it is often hard to know

whether the better results at one hospital are a result of superior care or healthier patients.

The inability to compare results across hospitals operating in heterogeneous environments is one reason why infection control practices have historically focused on benchmarking, internal trending, and performance improvement rather than on comparative measures. As CDPHE and the Colorado Health Facility-Acquired Infections Advisory Committee caution in their annual report on infections acquired in health care facilities:

...direct comparisons between facilities may not provide the most accurate assessment because infection rates are influenced by the types of patients treated. Facilities that treat higher volumes of severely ill patients may have higher infection rates regardless of their prevention efforts. While the NHSN system provides the best risk adjustment possible to account for this at present, there always will be patient risk factors that cannot be measured (e.g. individual ability to heal, smoking cessation days), especially in severely ill patients with higher risks of infection....[a]lthough the definitions and criteria are updated each year, they can be challenging to apply to patients with complicated medical histories. Additionally, facilities use different surveillance techniques to find infections...<sup>58</sup>

Given the uncertainty surrounding the entire subject of hospital quality indicators, any indicator involving public payments should aim at improving conditions for everyone by focusing on clear improvements that can reasonably be corrected without compromising care in other areas. Chosen indicators need to

---

Quality measures like those chosen by the Oversight Board are invariably politicized.

---

demonstrate a clear, stable, and clinically important relationship to the quality of care received by individual patients. They should also have such obvious benefits that almost all hospitals would voluntarily participate.

Medicaid spending patterns differ from those of Medicare and private insurers in important ways. Nationally, Medicaid paid for 16 percent of inpatient hospital costs, a smaller fraction of hospital payments than Medicare at 47 percent or private insurers at 29 percent. Table 6 shows the differences between the 10 highest expenditure hospital conditions for Medicare, private insurers, and Medicaid in 2011.<sup>59</sup> Four of Medicaid’s highest expenditure categories are related to giving birth. Previous C-Section, number 10 for Medicaid, is number 20 for private payers. It cost them \$1.2 billion and affected 255,000 patients. Medicare and the private sector have much larger costs for heart

attacks, joint replacements, coronary atherosclerosis, infection, and stroke.

The Hospital Provider Fee Oversight and Advisory Board Quality Initiative Program awards about \$61.4 million from the Hospital Provider Fee Cash Fund in a pay for performance program which is supposed to improve hospital quality. The measures chosen appear lopsided in their encouragement of behavior that might reduce Medicaid expenditures. The Quality Initiative Program report gives some support for this viewpoint by explaining that measures change over time because “the needs of Medicaid clients change over time.”<sup>60</sup>

Table 7 shows the measures used by the Board in recent years. A hospital earns up to 10 points for its performance in each of the 5 categories. Hospitals that do not offer one of the 5 base measure services can substitute one of the optional measures.

---

Chosen indicators need to demonstrate a clear, stable, and clinically important relationship to the quality of care received by individual patients.

---

Medicare	Private Insurer	Medicaid
Septicemia \$12.7 billion; 722,000	Liveborn \$5.8 billion; 1.8 million	Liveborn \$5.9 billion; 1.7 million
Osteoarthritis \$8.0 billion; 525,000	Osteoarthritis \$5.7 billion; 372,000	Septicemia \$2.7 billion; 113,000
Congestive heart failure, nonhypertensive \$7.6 billion; 739,000	Spondylosis, intervertebral disc disorders, other back problems \$4.7 billion; 280,000	Complication of device, implant, or graft \$1.4 billion; 71,000
Complication of device, implant or graft \$7.5 billion; 414,000	Septicemia \$3.7 billion; 189,000	Mood disorders \$1.4 billion; 244,000
Pneumonia \$6.7 billion; 667,000	Complications of device, implant, or graft \$3.2 billion; 173,000	Pneumonia \$1.3 billion; 152,000
Acute myocardial infarction \$6.3 billion; 351,000	Acute myocardial infarction \$3.2 billion; 161,000	Schizophrenia and other psychotic disorders \$1.2 billion; 130,000
Coronary atherosclerosis \$6.0 billion; 346,000	Coronary atherosclerosis \$3.3 billion; 169,000	Other complications of birth affecting management of the mother \$1.2 billion; 257,000
Respiratory failure \$5.5 billion; 263,000	Complications of surgical procedures or medical care \$2.1 billion; 181,000	Respiratory failure \$1.2 billion; 47,000
Cardiac dysrhythmias \$5.1 billion; 529,000	Pneumonia \$1.9 billion; 224,000	Other complications of pregnancy \$1.1 billion; 271,000
Acute cerebrovascular disease \$4.6 billion; 381,000	Acute cerebrovascular disease \$1.9 billion; 120,000	Previous C-section \$1.1 billion; 218,000

TABLE 7				
Measure	2012	2013	2014	2015
Central-line Associated Blood Stream Infection (CLABSI)	X	X	B	M
Postoperative Pulmonary Embolism/Deep Vein Thrombosis (PPE/DVT)	X	X	M	M
Early Elective Deliveries	X	X	B	B
Discharge instruction process	X			
30-day all-cause readmissions <sup>1</sup>		X	B	B
Cesarean Sections		X	B	B
Emergency Room Process <sup>2</sup>			B	B
Patient satisfaction				B
Culture of Safety				O
Active participation with a RCCO				O
Advance care planning				O
Tobacco screening and cessation <sup>3</sup>				O

B = Base Measure M = Maintenance Measure O = Optional Measure <sup>1,2,3</sup> - includes Medicaid patients only.

The Quality Initiative emergency room process measures, along with 30-day readmission rates, apply only to Medicaid patients. The process measures rate hospitals on whether they give Medicaid patients information about the Medicaid nurse advice lines, provide a list of nearby Medicaid primary care providers, and whether they send information about the visit to the local Medicaid Regional Care Collaborative Organization. They also rate hospitals on whether they have policies against replacing lost or stolen opiate pain killers.

Though these requirements may help Colorado Medicaid disseminate information to its clients, they are unlikely to improve an emergency department's ability to care for patients. In the worst case, they may consume emergency room resources that could be better used for other purposes, co-opting private resources for Medicaid administrative tasks that the state Medicaid program should be able to handle without imposing costs on hospitals and private payers.

To put the nurse advice line effort in context, consider that the Colorado Hospital Association reported about 1.8

million visits to Colorado emergency departments in 2014.<sup>61</sup> There were about 1.2 million people enrolled in Colorado Medicaid in 2014, and in FY 2014-15 there were just 32,202 calls to the Medicaid Nurse Advice Line. About half of the people making the calls, 16,654, said that they had gotten the number from the back of their Medicaid cards. Roughly equal numbers, 3,843 and 3,598 said that they had gotten the number online and from a wallet card. Another 1,000 reported getting the information from informational mailings or magnets.<sup>62</sup>

The patient satisfaction measure is based on the standardized HCAHPS survey. Unfortunately, it isn't clear exactly whether HCAHPS measures differences in hospitals or differences in patients. Hospitals with a high concentration of Medicaid patients are likely to have poorer patient experience rankings.<sup>63</sup> Rankings are better for physician owned hospitals, specialized hospitals, and hospitals in competitive markets.<sup>64</sup> The global rankings assigned by patients are also correlated with patient, hospital, and community characteristics.

---

Though these requirements may help Colorado Medicaid disseminate information to its clients, they are unlikely to improve an emergency department's ability to care for patients.

---

HCAHPS asks 27 questions of patients. It covers areas such as staff responsiveness, pain management, discharge information, medication communication, and room cleanliness. Its global measure asks patients to rank their hospital experience on a 1 to 5 scale. Of the fifty-one Colorado hospitals participating in October, 2015, two had a 2 star rating, twenty-four had a 3 star rating, twenty-one had a 4 star rating, and four had a 5 star rating.<sup>65</sup>

The Culture of Safety measure rewards hospitals for holding meetings. It assumes that holding the kinds of meetings it stipulates is the best use of hospital resources. Four of the quality incentive safety measures are 1) establishing a council with members who are former patients or family members of former patients that meets at least 4 times a year, 2) weekly safety meetings that hospital executives must attend in order to demonstrate leadership's commitment to a strong patient safety program, 3) a survey of hospital staff's perception of safety culture, 4) unit safety huddles in which nursing units and clinical departments hold daily meetings to discuss possible patient safety issues or concerns.

The early elective delivery and the cesarean section delivery measures, focus squarely on paying for changes in clinical decisions thought to increase expenditures on live births, a category which national statistics suggest is the highest expenditure category for the Medicaid program. The Hospital Provider Fee Cash Fund Quality Incentive Program rewards hospitals for eliminating early term elective deliveries (at 37 or 38 weeks gestation) and for lowering cesarean rates.

Although both measures are Joint Commission National Quality Core Measures, the evidence underlying them comes from older population based studies. Such studies are unsuited to predicting

the best gestational age of delivery for any given pregnancy. Hospitals exist to care for individual patients, not theoretical populations. Although Hospital Provider Fee Cash Fund quality payments may at present be too small to affect clinical judgment, as their importance grows they may reach the point where they create a conflict of interest between rewards from the state and the welfare of individual patients.

In a study of hospital discharges for deliveries at 37 or more weeks in New York City in 2010, neither the cesarean rate nor the rate of early elective deliveries was related to morbidity for normal newborns or their mothers. The authors concluded that "there were no correlations between the quality indicator rates and maternal and neonatal morbidity."<sup>66</sup> Other authors are concerned that the movement to end early elective deliveries coincides with an increase in US stillbirths and an increase in US maternal mortality and neonatal intensive care admissions.<sup>67</sup>

The cesarean pay for performance indicators pose a greater danger to babies and their mothers because they could end up pressuring physicians to do things that increase mortality for newborns and their mothers. Payments are maximized for hospitals with cesarean section rates at or below 15 percent. At present, participating hospitals with cesarean rates at or above 25 percent, a quarter of hospitals reporting, receive no payments. A 15 percent rate is almost certainly too low for average groups of patients, particularly if they include mothers who are older, obese, or diabetic.<sup>68,69</sup> Cesarean rates up to 20 per 100 live births have been found to be correlated with lower maternal mortality. Cesarean rates up to 24 per 100 have been found to lower neonatal mortality.<sup>70</sup> This suggests that quality incentive payments for reducing cesarean deliveries may reduce expenditures for births at the cost

---

The Culture of Safety measure rewards hospitals for holding meetings. It assumes that holding the kinds of meetings it stipulates is the best use of hospital resources.

---

of increased morbidity and mortality for babies and their mothers.

It is not even clear why the Quality Incentive Payment Program chose a 15 percent cesarean rate as its target. A 2015 presentation to the provider fee board cites the American Council of Obstetricians and Gynecologists (ACOG) as the source. Editorials on the ACOG website emphasize the importance of individualized patient care and attribute the cesarean section recommendation of 15 percent to the US Healthy People 2010 goals.<sup>71</sup> Other authors point to a 1985 World Health Organization (WHO) finding of no justification for population cesarean section rates higher than 10 to 15 percent.<sup>72</sup> Molina *et al.* have recently

presented evidence that rates higher than the WHO rate likely reduce maternal and infant morbidity.<sup>73</sup>

The Hospital Provider Fee Cash Fund payments for quality appear unrelated to the fees paid by hospitals. They may substitute for general government spending and preferentially focus on paying for performance likely to reduce Medicaid expenditure. It is unlikely that they confer any benefit on the people who bear the burden of the hospital provider charge.

---

The Hospital Provider Fee Cash Fund payments for quality appear unrelated to the fees paid by hospitals. They may substitute for general government spending and preferentially focus on paying for performance likely to reduce Medicaid expenditure. It is unlikely that they confer any benefit on the people who bear the burden of the hospital provider charge.

---

## **Hospital Provider Fee Cash Fund Redistribution—Some Patients Win and Some Patients Lose**

---

Virtually all discussions of Colorado’s provider charge treat hospitals as a monolithic block. It is frequently claimed that the provider charge costs hospitals nothing because the fee is refunded shortly after it is paid. According to a JBC report, “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 payments are disbursed almost as quickly as the money is collected, typically in a matter of minutes or hours rather than days.”<sup>74</sup>

Although “hospitals” as a group may have their fees repaid, Colorado’s “redistributive waiver” from the Centers for Medicaid and Medicare Services requires that the provider charge be structured to ensure that the state does not fully reimburse some individual hospitals for the provider

charge they pay.<sup>75</sup> It also means that the state should not use a portion of the provider charge revenue to compensate the people paying the tax.<sup>76</sup>

Table 8 shows the hospitals that have been net losers in the Hospital Provider Fee Cash Fund redistribution process over the last three years. The majority of the losers are privately owned. According to the Colorado Hospital Association, 36 percent of Colorado hospitals were owned by government in 2012.<sup>77</sup> Some, like Denver Health and the University of Colorado Hospitals, are run by hospital authorities, independent boards of directors appointed by political officials.

Although hospital systems could make up provider charge losses in one hospital with gains at another, the losses at some individual hospitals are quite large relative

	2013	2014	2015
Boulder Community Hospital	\$851,478	\$484,730	\$1,487,694
Castle Rock Adventist	NA	\$2,256,280	\$2,166,805
Centura Health--Littleton	\$5,055,636	\$5,099,333	\$5,524,488
Centura Health--Ortho CO	\$1,761,524	\$1,443,862	\$1,589,360
Centura Health--Parker	\$1,168,715	\$2,807,731	\$3,902,198
Centura Health--Penrose St Francis	\$8,527,141	\$368,168	NA
Centura Health--Porter	\$3,222,266	\$968,258	\$2,032,935
Centura Health--Saint Anthony	\$240,000	239,960	\$1,075,009
Community Hospital--Mesa	\$670,833	\$968,045	NA
Delta County Memorial	\$286,021	\$242,886	NA
Exempla Good Samaritan	\$4,468,202	\$4,284,150	\$7,173,138
HealthOne Sky Ridge	\$7,893,157	\$9,606,884	\$9,929,870
HealthOne--Aurora	\$559,238	NA	\$13,295,866
HealthOne--Swedish	\$5,183,479	\$4,932,712	\$187,358
Lutheran Medical Center		NA	\$5,643,704
Sources: Colorado Hospital Provider Fee Oversight and Advisory Board, <i>Colorado Health Care Affordability Act</i> , various years. Amounts are net reimbursement without CICP approximation. Years are Fiscal Years.			

---

Hospitals that gain from the provider charge redistribution process can do well.

---

to other expenditures. In 2014, the HCA-HealthOne system reported that it provided \$64.2 million in uncompensated care as a result of losses from charity care, discounts given to the uninsured, and losses from bad debt. The 2014 provider charge supplemental payment losses at two of its hospitals, Sky Ridge and Swedish, equaled \$14.5 million, a sum equal to 22 percent of the entire system's losses from uncompensated patient care.<sup>78</sup> The provider fee losses also exceeded the amount the system spent on health professional education, \$4.1 million, the amount it spent on community health improvement, \$6.7 million, and the amount it spent on research, \$1.8 million.

Catholic Health Initiatives, which operates Centura Health, reported that its 2015 income from operations was just under \$109.5 million based on an operating income of \$15.2 billion.<sup>79</sup> Its hospital losses from the provider charge redistribution process were more than \$14.1 million. Hospitals that gain from the provider charge redistribution process can do

well. In January, 2015, the Aspen Valley Hospital reported operating expenses of \$6.5 million and net operating revenue of \$8.1 million. Its operating margin was roughly \$1.6 million. Its biggest expense was \$2.6 million in salaries. According to the Hospital Provider Fee Oversight and Advisory Board, in federal fiscal year 2015-16 the Aspen Valley Hospital District could expect to pay slightly over \$1 million in provider fees and receive \$3.6 million in supplemental payments.<sup>80</sup> Aspen Valley Hospital will receive supplemental payments from the Hospital Provider Fee Cash Fund that are about 3.4 times more than it pays in fees.

With the exception of certain specialty hospitals that pay no fees, the hospitals that have the highest supplemental payment to fee ratio tend to be small rural facilities. Weisbrod Memorial County Hospital in Kiowa County provided 6,807 days of patient care in 2014 according to the Colorado Hospital Association. The Hospital Provider Fee Oversight and Advisory Board predicts that for



FFY 2015-16 it will pay almost \$40,000 in fees and receive more than \$900,000 in supplemental payments, a payment to fee ratio of about 24. Conejos County Hospital, a facility with a Level IV emergency room, will pay \$176,428 in fees and receive \$2,037,857 in payments. Its payment to fee ratio will be 11.6. In contrast, Sky Ridge Medical Center provided 46,550 days of patient care and had provider charge losses of \$9.6 million. The hospitals expected to receive the biggest gross payments from the Cash Fund for FY 2015-16 are Denver Health (\$119.2 million with a net gain after fees paid of \$96.2 million), the University of Colorado Hospital (\$70.1 million with a net gain of \$26.3 million), Memorial Hospital (\$65.7 million with a net gain of \$31.9 million), and Children's Hospital (\$52 million with a net gain of \$32.6 million).

If the amount that patients or their agents pay for services matters, and the whole premise of the hospital fee fund is that they do, then patients who pay for care at hospitals that consistently lose money get less than they pay for. The money must come from somewhere, either in higher charges for patients or a lower intensity of care.<sup>81</sup> In effect, government is using its legal authority to command funds from the customers of certain private businesses so that it can redistribute them to preferred enterprises in exactly the same business. The charge itself has no relationship to the actual cost of the services provided. It is pure redistribution, and redistribution is what government does with revenues from a tax.

---

## Why Does it Matter Whether it is Called a Provider Tax or a Provider Fee?

---

The Colorado Constitution requires a popular vote on any new tax. The hospital provider charge was passed in 2009, just months before the Great Recession hit its lowest point in June. At the time, it was clear to observers that Colorado's economically stressed voters would not approve any new tax. By calling the provider charge a fee rather than a tax, the legislature was able to collect and use the revenue from the provider charge without asking permission from the voters.

Opponents of the hospital Hospital Provider Fee Cash Fund say that the legislature called a tax a fee in order to evade the requirement to hold a popular vote. Proponents say that the charge is not a tax because it is used only to benefit

the people that pay it, it expands health coverage, and it is not used for any general state activities.

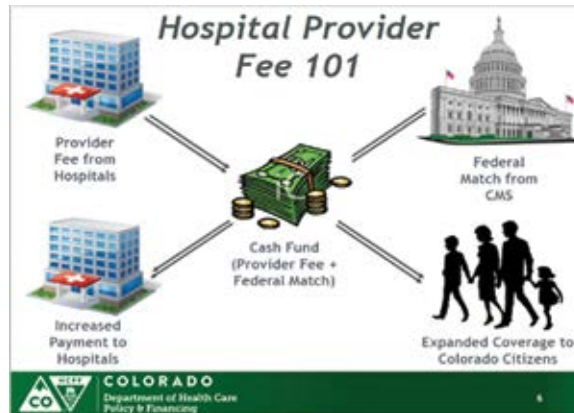
Figure 3 shows how state officials and groups that benefit from the Hospital Provider Fee Cash Fund typically explain Fund operations. They claim that the Fund returns the charge and spends the extra federal matching funds. They say that the state puts the matching funds to good use expanding Medicaid and offering incentives for hospital quality improvement. They ignore the fact that some hospitals and their patients consistently lose money from the provider fee program, that Fund monies have been used to substitute for General Fund spending, and the fact that coverage for

---

By calling the provider charge a fee rather than a tax, the legislature was able to collect and use the revenue from the provider charge without asking permission from the voters.

---

**FIGURE 3**  
**Money is Free! Provider Fee Advocates Ignore Federal Taxpayers**  
**and Hospital Fee Redistribution**



Colorado citizens is a general expense of government.

voters whether Colorado should expand Medicaid and CHP+.

---

Had the provider charge not been in place, state officials would likely have had to ask the voters whether Colorado should expand Medicaid and CHP+.

---

The 2016 Annual Report from the Provider Fee Oversight Board says that “after taking into account the total hospital provider fees collected for health coverage expansions, the Department’s administrative expenses, and the CICP hospital reimbursement level prior to increased payments” the net increase in supplemental payments to hospitals was “more than” \$334 million in 2014-15.<sup>82</sup> Estimates of the current state cost for the Obamacare Medicaid expansion assuming a 100 percent federal matching rate for 2016-17 are \$40,754,393. If the federal matching rate were to drop to 90 percent, the cost to the state would be \$144.2 million.

The Hospital Provider Fee Cash Fund pays for substantial increases in Medicaid supplemental payments and coverage expansions. The 2016 Annual Report from the Provider Fee Oversight Board says that the Fund spent \$1.4 billion on Medicaid expansions, and, as has been discussed above, state law turned some of its expansions into entitlements. Had the provider charge not been in place, state officials would likely have had to ask the

State officials would likely have had to ask because the amounts involved are large. For perspective, the Hospital Provider Fee Cash Fund represented 19.2 percent of non-General Fund sources subject to TABOR in FY 2014-15. It was the second largest source of non-General Fund money after the Highway Users Tax Fund (HUTF).<sup>83</sup> The \$688 million raised by the provider charge in federal FY 2014-15 was larger than all Motor Vehicle licenses, permits, and miscellaneous receipts collected in State FY 2014-15. It exceeded revenues from the corporate income tax. It was larger than the amounts from the highway fuel tax, the marijuana tax, taxes on limited stakes gaming, and taxes on tobacco products or alcohol. The only two sources of revenue that were larger were the general sales tax and the individual income tax.<sup>84</sup>

As explained above, Colorado redistributes the hospital provider charge and the federal matching funds. Hospitals neither pay the same charges nor receive the same supplemental payments. In practice, the patients who pay the fees at hospitals that routinely pay more in fees than they

receive in supplemental payments likely get fewer services than they pay for. They are harmed by the charge, as are the Colorado taxpayers who must pay higher federal taxes in order to create the higher federal matching funds.

Although individual hospitals that pay more in charges than they get in Hospital Provider Fee Cash Fund payments may be part of a hospital system with supplemental payments that exceed its provider charges, there is no guarantee that it will shift any excess to the less profitable loser hospitals. It may get the money from hospital customers. As is the case with a tax, ascertaining the actual incidence of Colorado's provider charge would be a complex undertaking.

Some advocates for financing Medicaid with provider charges argue that they are paid by patients. In a 2008 paper from

the Robert Wood Johnson Foundation's State Coverage Initiatives, Elliot K. Wicks explained that a provider tax was fair because it is "generally analogous to a sales tax on groceries: Almost everyone recognizes that most of the burden of that tax is borne by the consumers who buy the groceries, even though it is the grocer that sends the money to the state treasury."<sup>85</sup> Wicks also asserted that "just as private insurers and self-insured employers have paid for uncompensated care through the cost shift, they could generally be expected to pay for the increased net costs due to the tax, since the tax would apply to all providers and would be a legitimate cost of doing business."<sup>86</sup>

---

The idea of hospitals charging private payers more to make up for losses on uncompensated care and low government payments sounds reasonable only if one ignores how the people who pay the bills are likely to react. Private payers have the power to resist hospital price increases, and have a long history of doing so.

---

## Do Hospitals Cost Shift?

---

The elimination of the so-called hospital cost shift is often cited as a benefit that the provider fee confers on everyone who pays for his own hospital care. People who talk about the cost shift claim that hospitals increase the amount that they charge private payers in order to make up for low Medicaid reimbursements and uncompensated care costs. Hospitals are said to shift the cost of Medicaid to private payers. By increasing hospital compensation, the story goes, the Hospital Provider Fee Cash Fund helps keep private expenditures on hospital care from rising as fast as they otherwise would. If this is the case, then everyone benefits from the provider charge just as everyone benefits from fees to repair roads and bridges.

The idea of hospitals charging private payers more to make up for losses on uncompensated care and low government

payments sounds reasonable only if one ignores how the people who pay the bills are likely to react. Private payers have the power to resist hospital price increases, and have a long history of doing so. From 2003 to 2011 the average inflation-adjusted cost of a hospital stay increased just 1.9 percent, while average length of stay went down by 0.8 days.<sup>87</sup> If private payers resist higher prices, hospitals can respond to low Medicaid reimbursements in a variety of ways. The evidence suggests that one thing they can do is provide lower quality care to Medicaid patients.<sup>88</sup> They can do this by reducing capital expenditures<sup>89</sup> and offering less treatment.

Cost shift claims also ignore the fact that service providers generally resist charging less than they have previously been receiving for their services. If hospitals have the power to dictate higher prices

to private payers, as revenue maximizers it is likely that they will continue to do so regardless of the level of Medicaid compensation. After all, if a hospital is getting a higher price from private payers, what incentive does it have to lower that price simply because Medicaid the hospital is now getting larger supplemental payments from Medicaid?

Although lurid descriptions of cost shifting have long been used as talking points by interest groups invested in increasing Medicaid payments to hospitals, recent academic efforts have failed to find evidence that it exists. In a 2015 article in *Health Services Research*, economist Austin Frakt summed up the evidence and concluded that “recent studies have found no evidence of cost shifting.” He went on to say that:

---

Although lurid descriptions of cost shifting have long been used as talking points by interest groups invested in increasing Medicaid payments to hospitals, recent academic efforts have failed to find evidence that it exists.

---

Contrary to the cost shifting hypothesis, White found that a “10 percent reduction in the Medicare payment rate was associated with a 7.73 percent reduction in the private rate. This price spillover is the antithesis of cost shifting. Finally, He and Mellor (2012) also found evidence consistent with spillovers. In their analysis of outpatient surgical procedures at Florida hospitals during 1997-2008, they found that Medicare rate cuts were associated with an increase in volume from private insurers that paid fee-for-service prices. This volume shifting is inconsistent with cost shifting and is expected to accompany price spillovers. It suggests hospitals reduce private prices (though still keep them above Medicare rates) in response to lower Medicare ones to attract a larger volume of higher paying patients...In light of the evidence, any continued assumptions that most or all of

the shortfalls in Medicare rates can be shifted to private payers... should be relegated to the dustbin of history.<sup>90</sup>

Current data suggest that hospitals adjust to different payment levels by providing more care to people who pay more. Wu and Shen examined the long-term effect of Medicaid payments reductions on outcomes for heart attack patients. They concluded that hospitals that faced large cuts “saw smaller improvement in mortality rates relative to that of hospitals facing small cuts.”<sup>91</sup> Doyle et al. used random ambulance assignment in New York City to estimate the effects of increases in Medicare reimbursement. They found that mortality was lower for patients brought to higher cost hospitals.<sup>92</sup> Doyle found that people who had serious health emergencies far from home were more likely to survive if they were admitted to a hospital in a high spending area.<sup>93</sup>

If hospitals give more care to people who pay more, then extracting provider fees from hospitals that do not get supplemental payments means that their patients get less, even though they pay Colorado’s provider charge. It also means that patients who do not pay the charge by going to a hospital that gets paid far more in supplemental payments get care that is unrelated to the fees that they pay. This is in accord with the redistributive waiver from the Centers for Medicare and Medicaid Services that certifies the provider charge for Medicaid matching funds. It is also in accord with the statute’s creation of a Hospital Provider Fee Cash Fund to maximize Medicaid funding from the federal government. Based on Provider Fee Oversight Board Payments, the contents of the original Act, and requirements of the CMS waiver, it is reasonable to conclude that Colorado’s provider charges have little to do with the

services provided to the individual patient to whom the fee is charged. The inpatient charge operates like an excise tax on each day in the hospital, not like a traditional fee. Hospital days are classified according to the type of hospital and the type of coverage an individual has, and each day is taxed accordingly.

The outpatient fee operates like a sales tax. The amount charged is a percentage of the cost billed for the service. The billed charges vary with the amount an individual's insurer has agreed to pay, or the cash price a hospital charges. There are two different percentage rates depending upon whether or not

an individual receives services from a hospital that treats a lot of Medicaid and Colorado Indigent Care Program patients. The proceeds from the charge may be redistributed to hospitals that do not provide that service, state program administrators, or the General Fund.

---

Based on Provider Fee Oversight Board Payments, the contents of the original Act, and requirements of the CMS waiver, it is reasonable to conclude that Colorado's provider charges have little to do with the services provided to the individual patient to whom the fee is charged.

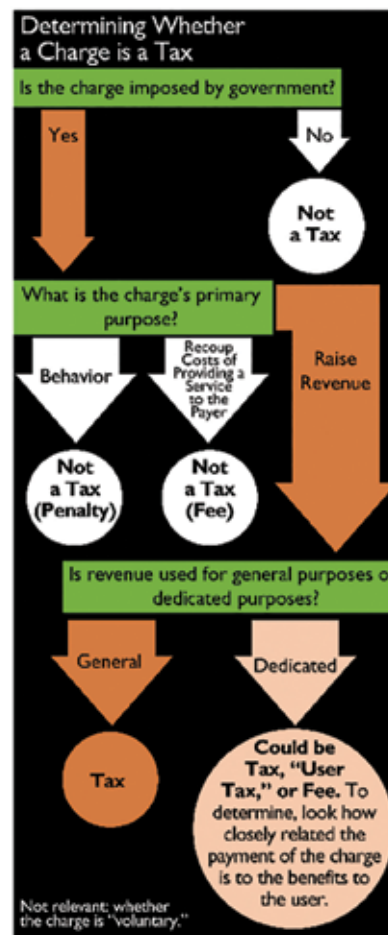
---

## Legal Definitions of Taxes and Fees

Joseph Henchman, The Tax Foundation's Vice President of Legal Projects, studied the definitions of tax and fee in U.S. jurisprudence. Figure 4, from the Tax Foundation, illustrates his conclusions.<sup>94</sup> He notes that the Colorado Supreme Court "explicitly rejected a voluntariness standard in *Bloom v. City of Fort Collins*" and stated instead that whether a charge is a fee or a tax depends upon whether "the fees were reasonably designated to offset the overall cost of services for which the fees were imposed."<sup>95</sup> On the basis of a 1984 case, Mr. Henchman concludes that "Colorado courts strictly construe ambiguous statutory language in favor of the taxpayer."<sup>96</sup>

Colorado courts have historically tried to determine the legislative attempt behind a charge by looking at the statutory language used. In *Barber v. Ritter*, the Colorado Supreme Court said that a fee was distinct from a tax in that it was not designed to raise revenues to defray the general

FIGURE 4



expenses of government, but rather is a charge imposed upon persons or property for the purpose of defraying the cost of a particular governmental service.

In order to consider the hospital provider charge a fee, one would have to argue that expanding the Medicaid program and increasing the amount that it pays for services is not a general expense of government, even when a program consumes more than 25 percent of state revenues. One would have to argue that Disproportionate Share Hospital payments and Colorado Indigent Care Program costs, expenses that were formerly considered part of general government expenses and appropriated from the General Fund, are no longer a general expense of government simply because they are now paid for by something called a fee. One would also have to argue that using the provider charge to supplement the General Fund and manipulate revenues in order to trigger road spending and avoid TABOR refunds did not serve the general purposes of government.

It is unfortunate that so much legal advice about the Hospital Provider Fee Cash Fund seems deficient in its understanding of how the General Fund, the Hospital Provider Fee Cash Fund distributions, and federal supplemental payments work together to fund Medicaid. In one example, a December 22, 2008, memo from the Colorado Office of Legislative Legal Services, the author declared that the hospital provider charge was a fee because:

It would not be intended to raise revenues for general government spending. Rather, the fees would be used to increase reimbursement rates for the hospitals that paid the fees.<sup>97</sup>

Given that some hospitals have lost money over each of the last three years, it is obviously not true that the fee revenues “are used to increase reimbursement rates for the hospitals that paid them.” In some cases, notably Craig Hospital and the HealthSouth Rehabilitation Hospitals in Denver and Colorado Springs, hospitals receive payments even though they pay no fees at all.

To help readers envision its alternate reality, the memo even explained how the fees would work:

The hospitals would benefit from paying the fees because the higher reimbursement rates would result in increased matching money from the federal government that would be used to both increase the hospital reimbursement rates and increase the number of persons eligible for benefits under Medicaid and the CHP+. As providers under those programs, the hospitals would see increased revenue generated by the increased number of recipients. Thus, the hospital provider fee would not be intended to generate, and would not result in, increased revenues for general governmental purposes.<sup>98</sup>

Setting aside the fact that some hospitals are net losers on fee reimbursements, it is possible that expanding Medicaid makes hospitals worse off. There is ample evidence that expanded Medicaid programs encourage people to substitute Medicaid for private health coverage. Prior to Obamacare, private insurers reimbursed at a higher rate than Medicaid. If all new Medicaid enrollees switched from being privately insured to being covered by Medicaid and utilization remained the same, hospital revenue would fall. Although the Colorado Hospital

---

In order to consider the hospital provider charge a fee, one would have to argue that expanding the Medicaid program and increasing the amount that it pays for services is not a general expense of government, even when a program consumes more than 25 percent of state revenues.

---

Association reports that unreimbursed care fell after Medicaid expansion, one cannot know what happened to revenues without looking at total reimbursement. Data from academic studies suggest that substitution rates are quite high. For every increase of 100 children covered under public insurance, 60 lose private insurance.

When family eligibility for public coverage is expanded, the substitution rate of public for private coverage can be as high as 80 percent.<sup>99</sup>

## Conclusion

---

The fact that the Hospital Provider Fee Cash Fund puts Medicaid funding on autopilot harms Colorado citizens by protecting the program's funding from full legislative scrutiny. This problem will be made worse if the Fund is hived off into an enterprise fund. Imagine an enterprise fund run by a special interest group consisting of Medicaid client hospitals, bureaucrats, and patients all seeking to enrich themselves by applying charges to hospital bills that inflate Medicaid charges for the purpose of extracting further funds from the federal government.

As those payments grow in importance, there is nothing to stop the managers of such a fund manipulating its payments to expand its power over both public and private hospitals. If history is any guide, that manipulation may not benefit the people who pay the provider charge. While it is likely to reduce Colorado Medicaid expenditures, this may be done at the expense of Medicaid recipients and patients covered by both Medicare and private insurance.

---

The fact that the Hospital Provider Fee Cash Fund puts Medicaid funding on autopilot harms Colorado citizens by protecting the program's funding from full legislative scrutiny.

---

# Endnotes

- <sup>1</sup> The Fund is referred to by a variety of names in state documents. This paper uses the nomenclature from the preamended version of HB 09-1293.
- <sup>2</sup> C.R.S. 25.5-4-402.3 (2015)
- <sup>3</sup> “Federal Fiscal Year 2015-16 Hospital Provider Fee and Supplemental Medicaid Payment,” 15.
- <sup>4</sup> The Fund is referred to by a variety of names in state documents. This paper uses the nomenclature from the preamended version of HB 09-1293.
- <sup>5</sup> The Colorado Indigent Care Program provides discounted health care services to people meeting specific income requirements. It is not an entitlement program. The state budgets an amount for it each year. To qualify, a single person’s annual income must be below \$29,175. Household income limits are increased by about \$10,000 per additional person. Recipients may not be eligible for Medicaid, enrolled in Medicare or have health insurance. They must be legally residing in Colorado. A variety of clinics and hospitals choose to participate in the CICP. Recipient costs vary with the provider.
- <sup>6</sup> Colorado’s cash funds usually contain revenues derived from a specific source that must be used for specific purposes. The General Fund contains revenues from general sources like the income and sales tax and can be used as the legislature sees fit.
- <sup>7</sup> C.R.S. 25.5-4-402.3 (2015)
- <sup>8</sup> A useful Government Accountability Office statistical compendium on provider taxes can be found at <http://www.gao.gov/special.pubs/gao-15-227sp/toc.htm>
- <sup>9</sup> The exact wording from C.R.S. 25.5-4-402.3 (2015) is “supplement, not supplant, general fund appropriations to support hospital reimbursements as of July 1, 2009. General fund appropriations for hospital reimbursements shall be maintained at the level of appropriations in the medical services premium line item made for the fiscal year commencing July 1, 2008.”
- <sup>10</sup> Raj Chetty, Adam Looney, and Kory Kroft, “Salience and Taxation: Theory and Evidence,” *American Economic Review* 99, no. 4 (August 2009): 1145–77, doi:10.1257/aer.99.4.1145. While hospital inpatient days are obviously a different commodity than alcohol purchases at the grocery store, it is well known that the demand for various kinds of health care is responsive to the prices faced by patients.
- <sup>11</sup> C.R.S. 25.5-4-402.3 (2015)
- <sup>12</sup> C.R.S. 29-28-103 (2015)
- <sup>13</sup> “Federal Fiscal Year 2015-16 Hospital Provider Fee and Supplemental Medicaid Payment” (State of Colorado, Department of Health Care Policy and Financing, February 19, 2016), 4, <https://www.colorado.gov/pacific/sites/default/files/2016%20FY%202015-16%20Hospital%20Provider%20Fee%20Overview%20updated.pdf>.
- <sup>14</sup> For a general outline of the federal definition see the Medicare Learning Network’s *Critical Access Hospital in the Rural Health Fact Sheet Series* from the Centers for Medicare & Medicaid Services. 2014. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CritAccessHospfactsht.pdf>
- <sup>15</sup> Hospital Provider Fee Oversight and Advisory Board, “Colorado Health Care Affordability Act Annual Report” (Denver, Colorado: Department of Health Care Policy and Financing, January 15, 2016), 4, [https://www.colorado.gov/pacific/sites/default/files/2016%20Annual%20Report\\_1.pdf](https://www.colorado.gov/pacific/sites/default/files/2016%20Annual%20Report_1.pdf).
- <sup>16</sup> *Ibid.*, 15.
- <sup>17</sup> *Ibid.*, 12.
- <sup>18</sup> Eric Kurtz, *Department of Health Care Policy and Financing, Staff Budget Briefing* (State of Colorado, Joint Budget Committee, December 8, 2015), 25, [http://www.tornado.state.co.us/gov\\_dir/leg\\_dir/jbc/2015-16/hcpbrfl.pdf](http://www.tornado.state.co.us/gov_dir/leg_dir/jbc/2015-16/hcpbrfl.pdf).
- <sup>19</sup> “Colorado Health Care Affordability Act Annual Report” (State of Colorado, Department of Health Care Policy and Financing, Hospital Provider Fee Oversight and Advisory Board, January 17, 2012).
- <sup>20</sup> Hospital Provider Fee Oversight and Advisory Board, “Colorado Health Care Affordability Act Annual Report,” 8.
- <sup>21</sup> Kurtz, “Department of Health Care Policy and Financing,” 40.
- <sup>22</sup> TABOR stands for Taxpayer Bill of Rights. It is Article X, Section 20 of the Colorado Constitution. It sets a limit on state tax collections. If the state collects more than that limit, the money must be refunded to taxpayers.
- <sup>23</sup> Kurtz, “Department of Health Care Policy and Financing,” 34.
- <sup>24</sup> *Ibid.*, 45.
- <sup>25</sup> “Colorado Claimed Unallowable Medicaid Nursing Facility Supplemental Payments” (Department of Health and Human Services, Office of Inspector General, September 2014). “Colorado Claimed Unallowable Medicaid Inpatient Supplemental Payments” (Department of Health and Human Services, Office of Inspector General, April 2014).
- <sup>26</sup> State of Colorado, Joint Budget Committee, “FY 2015-15 Budget Package and Long Bill Narrative,” 71, accessed March 8, 2016, [http://www.tornado.state.co.us/gov\\_dir/leg\\_dir/jbc/15LBNarrative.pdf](http://www.tornado.state.co.us/gov_dir/leg_dir/jbc/15LBNarrative.pdf).
- <sup>27</sup> “Medicaid Hospital Provider Fee Program, Department of Health Care Policy and Financing,” Performance Audit (State of Colorado, Office of the State Auditor, September 2012), 1, [http://www.leg.state.co.us/OSA/coauditor1.nsf/All/A942D0004D53D95D87257A9400721CE2/\\$FILE/Hospital%20Provider%20Fees%20Report%20COMPLETE%20FINAL%20PRINT%20READY9.26.12%20mg%20KM.pdf](http://www.leg.state.co.us/OSA/coauditor1.nsf/All/A942D0004D53D95D87257A9400721CE2/$FILE/Hospital%20Provider%20Fees%20Report%20COMPLETE%20FINAL%20PRINT%20READY9.26.12%20mg%20KM.pdf).
- <sup>28</sup> Kurtz, “Department of Health Care Policy and Financing,” 45.
- <sup>29</sup> “Continuous Eligibility: Frequently Asked Questions” (State of Colorado, Department of Health Care Policy and Financing, October 18, 2015), <https://www.colorado.gov/pacific/sites/default/files/Continuous%20Eligibility%20frequently%20asked%20questions.pdf>.
- <sup>30</sup> State of Colorado, Joint Budget Committee, “FY 2015-15 Budget Package and Long Bill Narrative,” 58.
- <sup>31</sup> Kurtz, “Department of Health Care Policy and Financing.”
- <sup>32</sup> “FY 2016-17 Medical Services Premiums Exhibits, Exhibit N” (State of Colorado, Department of Health Care Policy and Financing, n.d.), <https://www.colorado.gov/pacific/sites/default/files/HCPF%2C%20FY17%2C%20R-1%20Exhibits%20N.pdf>.
- <sup>33</sup> Leighton Ku and Teresa A. Coughlin, “Medicaid Disproportionate Share and Other Special Financing Programs,” *Health Care Financing Review* 16, no. 3 (Spring 1995).
- <sup>34</sup> As will be discussed below, a number of authorities do not believe that hospitals “cost shift.” If they are correct, the



- federal government developed a program to spend billions on a problem that did not exist
- <sup>35</sup> A short description of the timeline of the cat and mouse regulatory development is available from the GAO. James Cosgrove, Acting Director Health Care, *Medicaid Financing: Long-Standing Concerns About Inappropriate State Arrangements Support Need for Improved Federal Oversight* (United States Government Accountability Office, 2008), <http://www.gao.gov/assets/120/119542.pdf>.
- <sup>36</sup> “Medically Indigent and Colorado Indigent Care Program Fiscal Year 2014-15 Annual Report” (State of Colorado, Department of Health Care Policy and Financing, February 1, 2016), 27, <https://www.colorado.gov/pacific/sites/default/files/2014-15%20Annual%20Report%20Web.pdf>.
- <sup>37</sup> Hospital Provider Fee Oversight and Advisory Board, “Colorado Health Care Affordability Act Annual Report,” A2. Some hospitals are exempt from the obstetrician requirement.
- <sup>38</sup> “Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments,” Report to the Ranking Member, Committee on Finance, U.S. Senate (United States Government Accountability Office, May 2008), <http://www.gao.gov/assets/280/276050.pdf>.
- <sup>39</sup> “Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy,” Report to Congressional Requesters (United States Government Accountability Office, April 2015), 8, <http://www.gao.gov/assets/670/669561.pdf>.
- <sup>40</sup> Alison Mitchell, “Medicaid Provider Taxes,” CRS Report for Congress (Congressional Research Service, March 15, 2012), 1.
- <sup>41</sup> Alison Mitchell, “Medicaid Provider Taxes,” March 15, 2012, 1, <http://www.strategichealthcare.net/pdfs/45121463d.pdf>.
- <sup>42</sup> “Medicaid: Federal Guidance Needed to Address Concerns About Distribution of Supplemental Payments,” Report to the Committee on Finance, U.S. Senate (United States Government Accountability Office, February 2016), 11, footnote 15, <http://www.gao.gov/assets/680/675007.pdf>.
- <sup>43</sup> “Medicaid Financing: States’ Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection,” Report to Congressional Requesters (Washington, D.C: United States Government Accountability Office), 9, accessed March 7, 2016, <http://www.gao.gov/assets/670/665077.pdf>.
- <sup>44</sup> Hospital Provider Fee Oversight and Advisory Board, “Colorado Health Care Affordability Act Annual Report,” A1.
- <sup>45</sup> *Ibid.*, 8.
- <sup>46</sup> Chapin White and Vivian Yaling Wu, “How Do Hospitals Cope with Sustained Slow Growth in Medicare Prices?,” *Health Services Research* 49, no. 1 (February 2014): 26, doi:10.1111/1475-6773.12101. This paper also contains a useful summary of previous work on hospital price responsiveness.
- <sup>47</sup> “Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy,” 1.
- <sup>48</sup> *Ibid.*, 19.
- <sup>49</sup> BKD LLP, CPAs & Advisors, “Aspen Valley Hospital District, Independent Auditor’s Report and Financial Statements, December 31, 2013 and 2012,” Audit, (April 7, 2014), 26, <http://www.aspenvalleyhospital.org/userfiles/files/Aspen%20Final%202013%20FS.pdf>.
- <sup>50</sup> Kurtz, “Department of Health Care Policy and Financing,” 48.
- <sup>51</sup> Alfred E. Kahn, *The Economics of Regulation: Principles and Institutions* (Cambridge, Mass: MIT Press, 1988), 30.
- <sup>52</sup> Hospital Provider Fee Oversight and Advisory Board, “Colorado Health Care Affordability Act Annual Report,” 9.
- <sup>53</sup> Colorado Hospital Association website. <http://www.cha.com/Member-Services/CHA-DATABANK.aspx>, accessed February 18, 2016.
- <sup>54</sup> “Medicaid Hospital Provider Fee Program, Department of Health Care Policy and Financing.”
- <sup>55</sup> “Quality Strategy” (Colorado Department of Health Care Policy and Financing, 2007), <https://www.colorado.gov/pacific/sites/default/files/Quality%20Strategy.pdf>.
- <sup>56</sup> For an example and a guide to some of the literature on the subject see S I Saarni, “Evidence Based Medicine Guidelines: A Solution to Rationing or Politics Disguised as Science?,” *Journal of Medical Ethics* 30, no. 2 (April 1, 2004): 171–75, doi:10.1136/jme.2003.003145 and J. Russell et al., “Recognizing Rhetoric in Health Care Policy Analysis,” *Journal of Health Services Research & Policy* 13, no. 1 (January 1, 2008): 40–46, doi:10.1258/jhsrp.2007.006029.
- <sup>57</sup> Cynthia M. Boyd et al., “Clinical Practice Guidelines and Quality of Care for Older Patients With Multiple Comorbid Diseases: Implications for Pay for Performance,” *JAMA* 294, no. 6 (August 10, 2005): 716, doi:10.1001/jama.294.6.716.
- <sup>58</sup> “Health Care Associated Infections in Colorado, 2016 Annual Report” (Colorado Department of Public Health and Environment, Disease Control and Environmental Epidemiology Division, January 15, 2016), 9, [https://www.colorado.gov/pacific/sites/default/files/DC\\_ComDis-HAI-Annual-Report-2016.pdf](https://www.colorado.gov/pacific/sites/default/files/DC_ComDis-HAI-Annual-Report-2016.pdf).
- <sup>59</sup> Celeste M. Torio, PhD, MPH and Roxanne M. Andrews, PhD, “National Inpatient Hospital Costs: The Most Expensive Conditions by Payer, 2011,” Statistical Brief, Healthcare Cost and Utilization Project (United States Department of Health and Human Services, Agency for Healthcare Research and Quality, August 2013), <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb160.pdf>.
- <sup>60</sup> “Federal Fiscal Year 2015-16 Hospital Provider Fee and Supplemental Medicaid Payment,” 15.
- <sup>61</sup> “Colorado Hospital Association CHA DATABANK Program, 2014” (Colorado Hospital Association, March 16, 2015), <http://www.cha.com/getattachment/Resources/Colorado-Hospital-Utilization-Data/DATABANK-CHA-Web-Site-2014-Final-3-16-15.pdf.aspx>.
- <sup>62</sup> “Department of Health Care Policy and Financing FY 2016-17 Joint Budget Committee Hearing Agenda,” December 16, 2015, 52, <https://www.colorado.gov/pacific/sites/default/files/HCPF%20Main%20Briefing%20Responses%20to%20the%20JBC%202012.16.15.pdf>.
- <sup>63</sup> Sandra S. Liu et al., “Addressing Medicaid Expansion from the Perspective of Patient Experience in Hospitals,” *The Patient - Patient-Centered Outcomes Research*, March 22, 2016, doi:10.1007/s40271-016-0167-y.
- <sup>64</sup> S. C. Makarem and M. Al-Amin, “Beyond the Service Process: The Effects of Organizational and Market Factors on Customer Perceptions of Health Care Services,” *Journal of Service Research* 17, no. 4 (November 1, 2014): 399–414, doi:10.1177/1094670514541965.
- <sup>65</sup> Distribution of HCAHPS Summary Star Rating by US State, October 2015 Public Reporting. [http://www.hcahponline.org/Files/October\\_2015\\_Star\\_Ratings\\_Summary\\_State.pdf](http://www.hcahponline.org/Files/October_2015_Star_Ratings_Summary_State.pdf) as of April 2, 2016.

- <sup>66</sup> Elizabeth A. Howell et al., “Association Between Hospital-Level Obstetric Quality Indicators and Maternal and Neonatal Morbidity,” *JAMA* 312, no. 15 (October 15, 2014): 1531, doi:10.1001/jama.2014.13381.
- <sup>67</sup> James M. Nicholson et al., “US Term Stillbirth Rates and the 39-Week Rule: A Cause for Concern?,” *American Journal of Obstetrics and Gynecology*, forthcoming, February 2016, doi:10.1016/j.ajog.2016.02.019.
- <sup>68</sup> George Molina et al., “Relationship Between Cesarean Delivery Rate and Maternal and Neonatal Mortality,” *JAMA* 314, no. 21 (December 1, 2015): 2263, doi:10.1001/jama.2015.15553.
- <sup>69</sup> Sindhu K. Srinivas, Corinne Fager, and Scott A. Lorch, “Evaluating Risk-Adjusted Cesarean Delivery Rate as a Measure of Obstetric Quality,” *Obstetrics & Gynecology* 115, no. 5 (May 2010): 1007–13, doi:10.1097/AOG.0b013e3181d9f4b6.
- <sup>70</sup> Molina et al., “Relationship Between Cesarean Delivery Rate and Maternal and Neonatal Mortality.”
- <sup>71</sup> W. Lawrence Warner, MD, “Arriving at the Appropriate Cesarean Delivery Rate,” *ACOG*, July 2013, <http://www.acog.org/About-ACOG/ACOG-Departments/District-Newsletters/District-VIII/July-2013/Cesarean-delivery-rate>.
- <sup>72</sup> Ana Pilar Betran et al., “What Is the Optimal Rate of Caesarean Section at Population Level? A Systematic Review of Ecologic Studies,” *Reproductive Health* 12, no. 1 (December 2015), doi:10.1186/s12978-015-0043-6.
- <sup>73</sup> Molina et al., “Relationship Between Cesarean Delivery Rate and Maternal and Neonatal Mortality.”
- <sup>74</sup> Kurtz, “Department of Health Care Policy and Financing,” 41.
- <sup>75</sup> Cindy Mann, Provider Fee Medicaid Waiver Approval Letter from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Medicaid and State Operations to Sandeep Wadhwa, Medical Director, Colorado Department of Health Care Policy and Financing, March 30, 2010.
- <sup>76</sup> Mitchell, “Medicaid Provider Taxes,” March 15, 2012, 5.
- <sup>77</sup> “Colorado Hospitals by the Numbers” (Colorado Hospital Association, 2012), <http://www.cha.com/Colorado-Hospitals-Fact-Sheet.aspx>.
- <sup>78</sup> “2014 Annual Report” (HCA-HealthOne, LLC, 2014), 4, <http://healthonecares.com/util/documents/annual-reports/2014-Annual-Report.pdf>. The report specifically says that it does not include Medicaid in its uncompensated care estimate.
- <sup>79</sup> “2015 Financial Report” (Catholic Health Initiatives, 2015), <http://chiannualreport.net/2015Pdfs/Financials.pdf>.
- <sup>80</sup> “Aspen Valley Hospital Profit and Loss Statement for the Period Ending Jan 2015,” 2016, <http://www.aspenvalleyhospital.org/userfiles/files/FINANCIALS%20TO%20BOD%20JAN%2015.pdf>.
- <sup>81</sup> There is growing evidence that higher hospital expenditures do reduce mortality and morbidity. Previous claims that this was the case primarily observed Medicare patients and did not take into account area differences in patient morbidity. For examples see J. D. Reschovsky, J. Hadley, and P. S. Romano, “Geographic Variation in Fee-for-Service Medicare Beneficiaries’ Medical Costs Is Largely Explained by Disease Burden,” *Medical Care Research and Review* 70, no. 5 (October 1, 2013): 542–63, doi:10.1177/1077558713487771 and Joseph Doyle et al., “Do High-Cost Hospitals Deliver Better Care? Evidence from Ambulance Referral Patterns” (Cambridge, MA: National Bureau of Economic Research, March 2012), <http://www.nber.org/papers/w17936.pdf>.
- <sup>82</sup> Hospital Provider Fee Oversight and Advisory Board, “Colorado Health Care Affordability Act Annual Report,” 4.
- <sup>83</sup> Kurtz, “Department of Health Care Policy and Financing,” 43.
- <sup>84</sup> “Colorado Department of Revenue 2015 Annual Report, July 1, 2014-June 30, 2015” (State of Colorado, Department of Revenue, January 1, 2016), 46, [https://www.colorado.gov/pacific/sites/default/files/2015%20Annual%20Report\\_1.pdf](https://www.colorado.gov/pacific/sites/default/files/2015%20Annual%20Report_1.pdf).
- <sup>85</sup> Elliot K. Wicks, “Can a Sales Tax on Medical Services Help Fund State Coverage Expansions?,” *State Coverage Initiatives* (Robert Wood Johnson Foundation, July 2008), 5, [http://academyhealth.org/files/publications/SCI\\_SalesTax.pdf](http://academyhealth.org/files/publications/SCI_SalesTax.pdf).
- <sup>86</sup> *Ibid.*, 6.
- <sup>87</sup> Audrey J. Weiss, PhD, Marguerite L. Barrett, MS, and Caludia A. Steiner, MD MPH, “Trends and Projections in Inpatient Hospital Costs and Utilization, 2003-2013,” *Statistical Brief, Healthcare Cost and Utilization Project* (United States Department of Health and Human Services, Agency for Healthcare Research and Quality, July 2014), <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb175-Hospital-Cost-Utilization-Projections-2013.pdf>.
- <sup>88</sup> Rachel M. Werner, “Comparison of Change in Quality of Care Between Safety-Net and Non-Safety-Net Hospitals,” *JAMA* 299, no. 18 (May 14, 2008): 2180, doi:10.1001/jama.299.18.2180.
- <sup>89</sup> Seth Freedman, Haizhen Lin, and Kosali Simon, “Public Health Insurance Expansions and Hospital Technology Adoption,” *Journal of Public Economics* 121 (January 2015): 117–31, doi:10.1016/j.jpubeco.2014.10.005.
- <sup>90</sup> Austin B. Frakt, “The End of Hospital Cost Shifting and the Quest for Hospital Productivity,” *Health Services Research* 49, no. 1 (February 2014): 2–3, doi:10.1111/1475-6773.12105.
- <sup>91</sup> Vivian Y. Wu and Yu-Chu Shen, “Long-Term Impact of Medicare Payment Reductions on Patient Outcomes,” *Health Services Research* 49, no. 5 (October 2014): 1596–1615, doi:10.1111/1475-6773.12185.
- <sup>92</sup> Doyle et al., “Do High-Cost Hospitals Deliver Better Care?”
- <sup>93</sup> Joseph J. Doyle, “Returns to Local-Area Health Care Spending: Evidence from Health Shocks to Patients Far From Home,” *American Economic Journal: Applied Economics* 3, no. 3 (July 2011): 221–43, doi:10.1257/app.3.3.221. “Medicaid Buy-In Program for Working Adults with Disabilities: Income Chart and Premium Guide” (State of Colorado, Department of Health Care Policy and Financing, April 2014), [https://www.colorado.gov/pacific/sites/default/files/Adult%20Buy-In%20Income\\_Chart%20and%20Premium%20Guide-April%202014.pdf](https://www.colorado.gov/pacific/sites/default/files/Adult%20Buy-In%20Income_Chart%20and%20Premium%20Guide-April%202014.pdf).
- <sup>94</sup> Tax Foundation, *Determining Whether a Charge Is a Tax*, accessed March 7, 2016, <http://taxfoundation.org/article/how-money-used-federal-and-state-cases-distinguishing-taxes-and-fees>.
- <sup>95</sup> Joseph Henchman, “How Is the Money Used? Federal and State Cases Distinguishing Taxes and Fees,” *Background Paper No. 63* (The Tax Foundation), accessed March 5, 2016, <http://taxfoundation.org/sites/default/files/docs/TaxesandFeesBook.pdf>. This section relies heavily on Mr. Henchman’s report. The quote is from page 25 of the report.
- <sup>96</sup> Mr. Henchman’s citation is *Transponder Corp. of Denver, Inc. v. Prof. Tax Adm’r*, 681 P.2d 499, 504 (Colo. 1984) (“A ‘longstanding rule of statutory construction’ in Colorado is that tax statutes ‘will not be extended beyond the clear import of the language used, nor will their operation be extended by analogy . . . . All doubts will be construed against the government and in favor of the taxpayer.’ (quoting *Associated Dry Goods v. City of Arvada*, 593 P.2d 1375, 1378 (Colo. 1979))). *Ibid.*, 26.

<sup>97</sup> Office of Legislative Legal Services, Colorado General Assembly, “Whether a ‘Hospital Provider Fee’ Is a Tax for Purposes of Section 20 (4) (a) of Article X of the Colorado Constitution [Legal Memorandum],” December 22, 2008, [http://www.leg.state.co.us/Clics/Clics2009A/commsumm.nsf/91320994cb8e0b6e8725681d005cb995/44fcb0f884e9ad18872575780068ae4c/\\$FILE/09HouseHHS0313AttachA.pdf](http://www.leg.state.co.us/Clics/Clics2009A/commsumm.nsf/91320994cb8e0b6e8725681d005cb995/44fcb0f884e9ad18872575780068ae4c/$FILE/09HouseHHS0313AttachA.pdf).

<sup>98</sup> Ibid., 3.

<sup>99</sup> Jonathan Gruber and Kosali Simon, “Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?” (Cambridge, MA: National Bureau of Economic Research, January 2007), <http://www.nber.org/papers/w12858.pdf>.

Copyright ©2016, Independence Institute

INDEPENDENCE INSTITUTE is a non-profit, non-partisan Colorado think tank. It is governed by a statewide board of trustees and holds a 501(c)(3) tax exemption from the IRS. Its public policy research focuses on economic growth, education reform, local government effectiveness, and constitutional rights.

JON CALDARA is President of the Independence Institute.

DAVID KOPEL is Research Director of the Independence Institute.

LINDA GORMAN is the Director of the Health Care Policy Center.

ADDITIONAL RESOURCES on this subject can be found at: [www.i2i.org/health-care](http://www.i2i.org/health-care).

NOTHING WRITTEN here is to be construed as necessarily representing the views of the Independence Institute or as an attempt to influence any election or legislative action.

PERMISSION TO REPRINT this paper in whole or in part is hereby granted provided full credit is given to the Independence Institute.



**INDEPENDENCE**  
INSTITUTE.ORG

727 East 16th Avenue | Denver, Colorado 80203

[www.IndependenceInstitute.org](http://www.IndependenceInstitute.org) | 303-279-6536 | 303-279-4176 fax