Legislative Council Staff
Nonpartisan Services for Colorado's Legislature

Memorandum

August 18, 2025

TO: Interested Persons

FROM: Kristine McLaughlin, Fiscal Analyst, 303-866-4776

SUBJECT: Hospital Provider Fee

Summary

The Health Care Affordability Act of 2009, House Bill 09-1293, authorized the collection of a provider fee from most Colorado hospitals. Senate Bill 17-267 created the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) under the Department of Health Care Policy and Financing (HCPF). CHASE charges hospitals a successor to the original fee, now known as the Healthcare Affordability and Sustainability (HAS) fee, to draw additional federal funds that are passed on to hospitals though lowered uninsured rates and supplemental payments.

In FY 2024-25, HAS fee revenue totaled about $1.2 billion and total revenue to the HAS Cash Fund, which includes this fee revenue, federal funds, and interest, totaled over $5 billion. The fund represents about 90 percent of HCPF's cash fund revenue. None of the sources of revenue deposited in the cash fund is subject to TABOR.

This memorandum discusses the following topics related to the HAS Cash Fund:

- assessment and collection;
- federal match rates;
- disbursements to hospitals; and
- implications of 2025 H.R. 1, also known as the One Big Beautiful Bill Act or OBBBA.

Acronyms used in this memorandum include:

- CHASE, Colorado Healthcare Affordability and Sustainability Enterprise;
- CHP+, Children's Basic Health Plan Plus;
- CMS, Centers for Medicare and Medicaid Services;
- HAS, Healthcare Affordability and Sustainability; and
- HCPF, Department of Health Care Policy and Financing.

Assessment and Collection

CHASE collects HAS fees from most hospitals in the state; however, state law exempts the following hospitals from fee requirements:

- psychiatric hospitals;
- long-term care hospitals certified by the Department of Public Health and Environment; and
- inpatient rehabilitation hospitals.

These fees are set by the state Medical Services Board, which is responsible for promulgation of all HCPF rules. The Medical Services Board bases fees on recommendations from the CHASE Board. Additionally, each year's fee schedule must be approved by the federal CMS. Fees are set such that they do not exceed limits on fee revenue contained in state law and in federal regulations.

Limits on Fee Revenue

Pursuant to federal regulations, the amount that the state collects from the HAS fee may not exceed the lesser of:

- 6 percent of hospitals' net patient revenue (set to gradually lower over four years, see the Implications of H.R. 1 section of this memorandum); or
- the state's upper payment limit.

The state's upper payment limit is calculated by a formula set in federal regulations. The upper payment limit generally expresses the difference between the total health care costs paid for Medicaid-covered patients and total costs that would have been paid for those patients if they were covered under Medicare instead.

Current Fee Schedule

Fees are currently set to reach 99.25 percent of the upper payment limit. The fee schedule, as authorized by the Medical Services Board, includes inpatient and outpatient fee assessments.

The inpatient services fee is computed according to the number of days of care provided by the hospital, as shown in Table 1. The inpatient fee amount depends on if care is paid for through a managed care plan. The outpatient services fee, shown in Table 2, is computed as a percentage of total outpatient charges.

Certain hospitals are exempt or given a discounted rate but this may be subject to change as a result of H.R. 1 (see the Implications of H.R. 1 section of this memorandum).

Table 1
Inpatient Services Fee Schedule

Hospital Type	Psychiatric, Long Term Care, and Rehabilitation Hospitals	Essential Access Hospitals	High Volume Medicaid Hospitals	All Other Hospitals
Managed Care Days	Exempt	$48.87/day	$63.79/day	$122.18/day
All Other Days	Exempt	$218.46/day	$285.14/day	$546.15/day

Source: 10 CCR 2505-10 (8.3003.B).
"Essential access hospitals" are located in rural areas with 25 or fewer licensed beds.
"High volume Medicaid hospitals" are those with at least 35,000 Medicaid care days per year.
"Managed care days" are days for which the primary payer is a managed care health plan.

Table 2
Outpatient Services Fee Schedule

Hospital Type	Psychiatric, Long Term Care, and Rehabilitation Hospitals	High Volume Medicaid Hospitals	All Other Hospitals
Outpatient Charges	Exempt	1.7869 percent	1.8020 percent

Source: 10 CCR 2505-10 (8.3003.A).
Pursuant to rule, HCPF assesses fees on an annual basis and collects fees in twelve monthly installments.[1] Fee revenue is collected in the HAS Cash Fund.

Disbursements to Hospitals

The HAS Cash Fund is used to:

- fund health care for Medicaid and CHP+ expansion populations;
- issue supplemental payments to hospitals for uncompensated health care;
- pay for administration of CHASE; and
- offset losses in federal matching funds if public expenditures are not certified for certain outpatient procedures.

[1] 10 CCR 2505-10 (8.2002.B (3)).

Expenditures of the HAS Cash Fund totaled almost $5 billion for FY 2023-24, the most recent year for which data are available. These included:

- $3.1 billion for Medicaid and CHP+ expansion populations;
- $1.7 billion for supplemental payments to hospitals;
- $125 million for fee administration; and
- $7 million to offset lost matching funds.

Expansion Populations

The Affordable Care Act (ACA) expanded Medicaid to populations by lessening income restrictions. CHP+ offers publicly funded insurance to children and pregnant women who still do not qualify for Medicaid but cannot afford private insurance.

The state pays for these expanded populations through the HAS Cash Fund to receive the enhanced federal match discussed in the Federal Match Rates section of this memorandum.

Expansion populations have access to all the same services as standard Medicaid clients but their utilization historically differs. The Fund 2410 section of HCPF's Cash Fund Report shows how HAS funds are spent by program.

Expanding the population eligible for publically funded insurance reduces the uninsured rate, disbursing HAS fund revenue back to hospitals based on services provided to expansion clients.

Supplemental Payments

Supplemental payments are apportioned according to formulas established by the CHASE Board and CMS. Under CMS regulations, the formula must be redistributive, meaning that supplemental payments may not be proportional to fee amounts paid by individual hospitals. The CHASE Board determines the factors in the formula and the weight to give each factor, which ultimately controls the amount each hospital receives.

There are currently six supplemental payment programs. In FY 2023-24, payments included:

- $698 million for the Inpatient Supplemental Payment;
- $633 million for the Outpatient Supplemental Payment;
- $128 million for the Hospital Quality Incentive Supplemental Payment;
- $257 million for the Disproportionate Share Hospital Supplemental Payment;
- $26 million for the Essential Access Supplemental Payment; and
- $12 million for the Rural Support Supplemental Payment.

Details on each program can be found starting on page 15 of the CHASE annual report.

Federal Match Rates

Fee revenue collected from hospitals is matched with federal funds before being disbursed to HCPF and hospitals for expenditure. The federal government applies different match rates according to the purpose and populations for which funds will be expended. The minimum match rate is 50 percent, one federal dollar per state dollar. However, as shown on page 26 of HCPF's Cash Fund Report, of the $5 billion in HAS fund revenue received in FY 2023-24, $3.7 billion, or over 74 percent, came from federal funds. This is because most HAS fee revenue is expended on expansion clients who receive an enhanced federal match.

Currently about 427,000 expansion population clients are funded though the HAS fee. Of these, 320,000 are adults without dependent children earning up to 133% of the federal poverty limit.[2] This population receives a 90 percent federal match.

Implications of H.R. 1

Congress passed H.R. 1 – The One Big Beautiful Bill Act, which became law in July 2025. Subtitle B, Chapter 1 of the act includes five subchapters concerning changes to Medicaid. Subchapter C, Sections 71115 and 71117, include changes that directly impact the provider fee.

As discussed above, currently fee revenue is limited to six percent of hospitals' net patient revenue (though this limit is not always binding because of the upper payment limit). Section 71115 reduces this limit by half a percent annually, starting in October 2027 and continuing until it reaches 3.5 percent. HCPF estimates this will reduce federal funds by between $900 million and $2.5 billion when fully implemented.[3]

When the Health Care Affordability Act of 2009 allowed for the HAS fee, it required it to be uniformly applied on all providers but allowed the U.S. Secretary of Health and Human Services to allow exceptions if the fee was "generally redistributive." Section 71117 further defines "generally redistributive" to ensure financial participation from hospitals that service fewer Medicaid clients. To date, HCPF has not identified any needed change to fee collection or disbursements, but this is subject to change with legal and federal guidance.

[2] CHASE Annual Report

[3] Starting at 10:45 on July 30, 2025, HCPF presented to the Executive Committee of the Legislative Council on the impact on H.R.1. Starting at 11:11 they discussed the impact on the provider fee.