Colorado Center on Law & Policy Issue Brief:

How Proposed State Budget Cuts Could Impact Health Access in Rural Colorado

By Charles Brennan

Highlights

- More than half of Coloradans living in rural areas receive health care coverage through Health First Colorado (26 percent), Medicare (15.7 percent), or are uninsured (11.4 percent).
- Most rural counties are considered Primary Care, Dental, or Mental Health Professional Shortage Areas (HPSAs), Medically Underserved Areas (MUAs), or Medically Underserved Populations (MUPs) and rank poorly in terms of residents' access to health care services.
- Community Health Centers across the state have a positive economic impact on their communities, creating 10,542 jobs, generating $1.4 billion in economic activity and $51 million in state and local taxes.
- Every physician employed by a Rural Health Clinic (RHC) or Critical Access Hospital (CAH) creates approximately 26 additional jobs and nearly $1.4 million in economic activity.
- 18 out of 42 rural hospitals in the state operated with negative profit margins in 2019.
- Half of respondents to a Colorado Rural Health Center member survey in March 2020 had less than 57 days cash on hand to pay for operations, maintenance, employees, and equipment.
- The JBC agreed to a number of cuts in the Long Appropriations Bill that would have an impact on access to health care for Coloradans living in rural areas. In total, the Long Bill proposes a $1.2 billion (11.3 percent) cut in total funds to the Department of Health Care Policy and Financing (HCPF) for FY 2020-21, including a $371.8 million decrease (12.4 percent) in General Fund appropriations.
- Cuts include: undoing a Community Provider Rate increase, decreasing overall provider reimbursement by 1 percent, raising Medicaid copays to the federal maximum, capping dental benefits at a lower level, reducing outreach to families with children in the Healthy Communities program; and transferring $161 million out of the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) fund that helps support hospitals with high rates of Medicaid-enrolled or uninsured patients.
- Adjustments include: using additional federal funds available through a 6.2% higher federal match for general HCPF program needs, rather than raising provider reimbursement; delaying implementation of the state's residential substance use disorder (SUD) treatment benefit by 6 months; and, due to cuts in the budget for the Colorado Department of Human Services, reductions in behavioral health provider reimbursement and rural SUD treatment capacity.
- Programs that were not cut include: Reinsurance, CHP+, the Primary Care Fund and the Colorado Indigent Care program.

Introduction

The COVID-19 pandemic has resulted in a fiscal crisis for the State of Colorado. Fiscal year (FY) 2020-2021 revenue projections by the state Legislative Council predict the General Assembly will face a $3.3 billion budget shortfall, requiring an over 25 percent cut in current spending.[1] This historic shortfall will require major cuts from the state's budget. If lawmakers fail to raise additional revenue through an emergency TABOR tax or receive aid from the federal government, state government services, particularly those that working families depend on, will be drastically reduced if not eliminated. Health care is no exception.

Although lawmakers have chosen not to reduce caseloads or cut benefits for keystone programs such as Health First Colorado[2] and Children's Health Plan Plus (CHP+) for the duration of the public health emergency,[3] proposed cuts to the Department of Health Care Policy and Financing's (HCPF's) budget will likely have adverse effects to Coloradans' ability to access health care (related or unrelated to the pandemic), particularly in rural areas. Provider availability was an issue in rural Colorado prior to COVID-19 and many rural health clinics and hospitals were operating at a loss before the pandemic hit. According to a factsheet from the Colorado Rural Health Center, 18 out of 42 (or 42.9 percent) of rural hospitals in the state operated with negative profit margins in 2019.[4] Although hospitals and other care providers received funds through the federal CARES Act, this money can only be used for costs associated with the COVID-19 pandemic, raising questions as to how exactly providers can use the additional funds. Budget cuts agreed to by the Joint Budget Committee (JBC) would result in a reduction of funding for many of these facilities, putting them in an even more precarious financial position. Some will likely have to close their doors without an infusion of unrestricted funds.

Health Access in Rural Colorado Pre-COVID-19

A range of factors make it difficult both for Coloradans living in rural areas of the state to access health care, as well as for providers in rural areas to provide care. These include travel distances to providers, lack of options for providers and specialists, Poor access and care options for rural residents is compounded by the fact that more than half of Coloradans living in rural areas receive health care coverage through Health First Colorado, Medicare, or are uninsured.[5] This is in stark difference to urban counties, where 62.7% of residents received health care coverage from a private insurer. Over one in four rural residents receives health coverage through Health First Colorado, meaning changes to this program, including reimbursement rates to providers, have a disproportionate impact on rural Coloradans. This is also a challenge for Coloradans in rural areas, as providers may or may not choose to accept Medicaid patients.[6]

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[1] *May 2020 Economic & Revenue Forecast Update*. Colorado Legislative Council Staff (2020). Colorado General Assembly. State of Colorado. https://leg.colorado.gov/publications/forecast-update-may-2020

[2] Colorado's Medicaid program

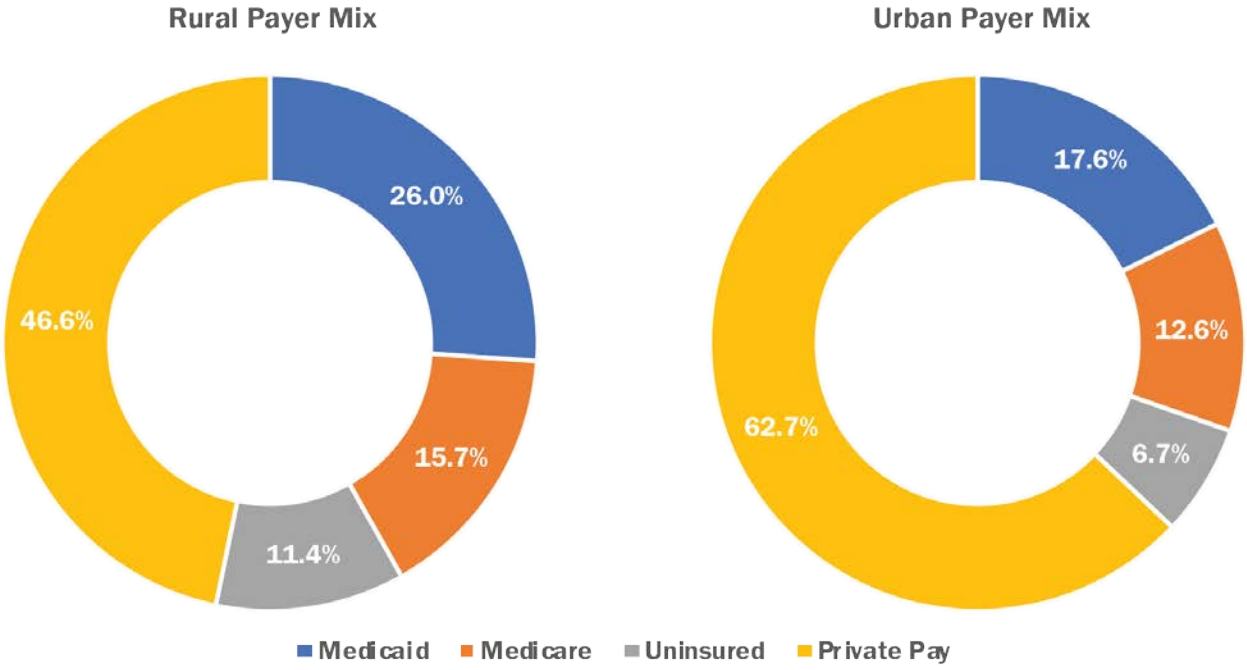
[3] As determined by the Secretary of Health and Human Services.

[4] *COVID-19 and a Looming Rural Health Crisis*. Colorado Rural Health Center (2020). http://www.coruralhealth.org/covidfinancials

[5] *Snapshot of Rural Health in Colorado 2020*. Colorado Rural Health Center (2020). https://coruralhealth.org/snapshot-of-rural-health.

[6] One reason for this is that the cost of serving Medicaid patients is often higher than the amount HCPF reimburses providers. According the HCPF's 2020 Cost Shift Analysis, hospital providers in 2018 were only compensated $0.77 for every $1.00 spent on care for Medicaid patients, compared to $1.70 for every $1.00 spent on care for patients with private insurance.

Figure 1. Insurance Payer Mix in Urban and Rural Colorado

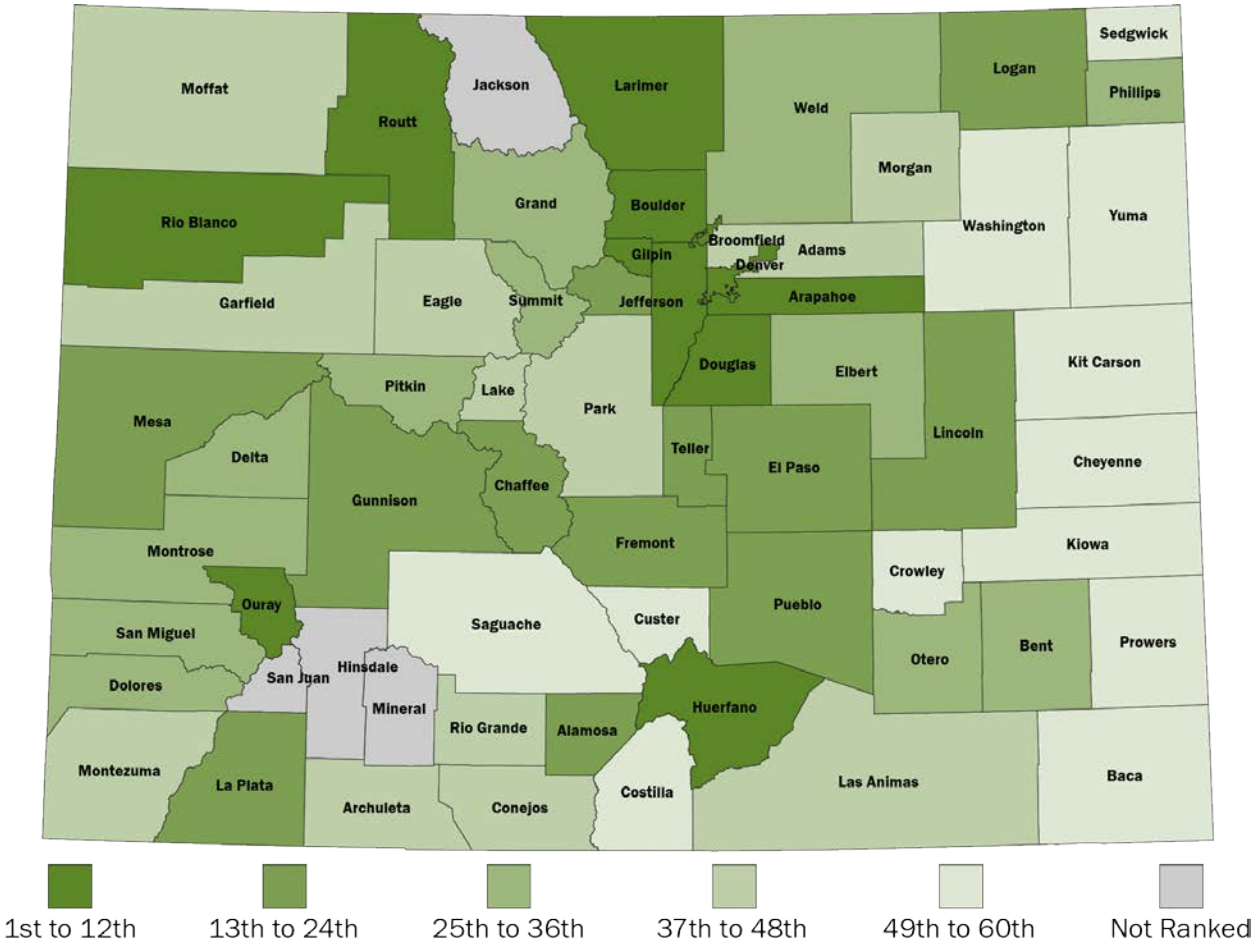


Source: Colorado Rural Health Center

The Robert Wood Johnson Foundation's (RWJF's) County Health Rankings provides one standardized method for evaluating health access in different counties across Colorado. Based on the normalized weighted scores of four access-related indicators,[7] the model ranks Colorado's counties from those with the best access to care to those with the worst. While access is just one component of their larger model, it is informative to isolate this aspect of health to understand how access varies across the state. As shown in the map below, rural counties, by and large, rank lower than urban counties in access to care.

[7] The four indicators and their weights are: the percentage of the population that is uninsured (weighted 5%); the number of primary care physicians per population (weighted 3%), the number of dentists per population (weighted 1%) and the number of mental health providers per population (weighted 1%). Together these indicators make up the "Access to care" portion of RWJF's health model. These weights were determined based on extensive research on factors that contribute to a community's health. See more at: https://www.countyhealthrankings.org/.

Figure 2. 2020 Access to Care Rankings - Colorado



Note: 1st is best in the state while 60th is worst in the state.
Source: Robert Wood Johnson Foundation – County Health Rankings; Colorado Center on Law and Policy

This trend is confirmed by the federal government, which uses two geographic designations to increase access to health care in both rural and urban areas: Health Professional Shortage Areas (HPSAs)[8] and Medically Underserved Areas (MUAs)/Medically Underserved Populations (MUPs).[9] These designations are important to the rural health safety net, as medical providers located in these areas are eligible to be designated as Rural Health Clinics (RHCs) or Federally Qualified Health Centers (FQHCs). Although these designations have different requirements, both provide essential services to Medicaid patients (and those without insurance in the case of FQHCs) in rural Colorado. Currently there are 52 RHCs and 66 FQHCs serving rural Colorado.[10]

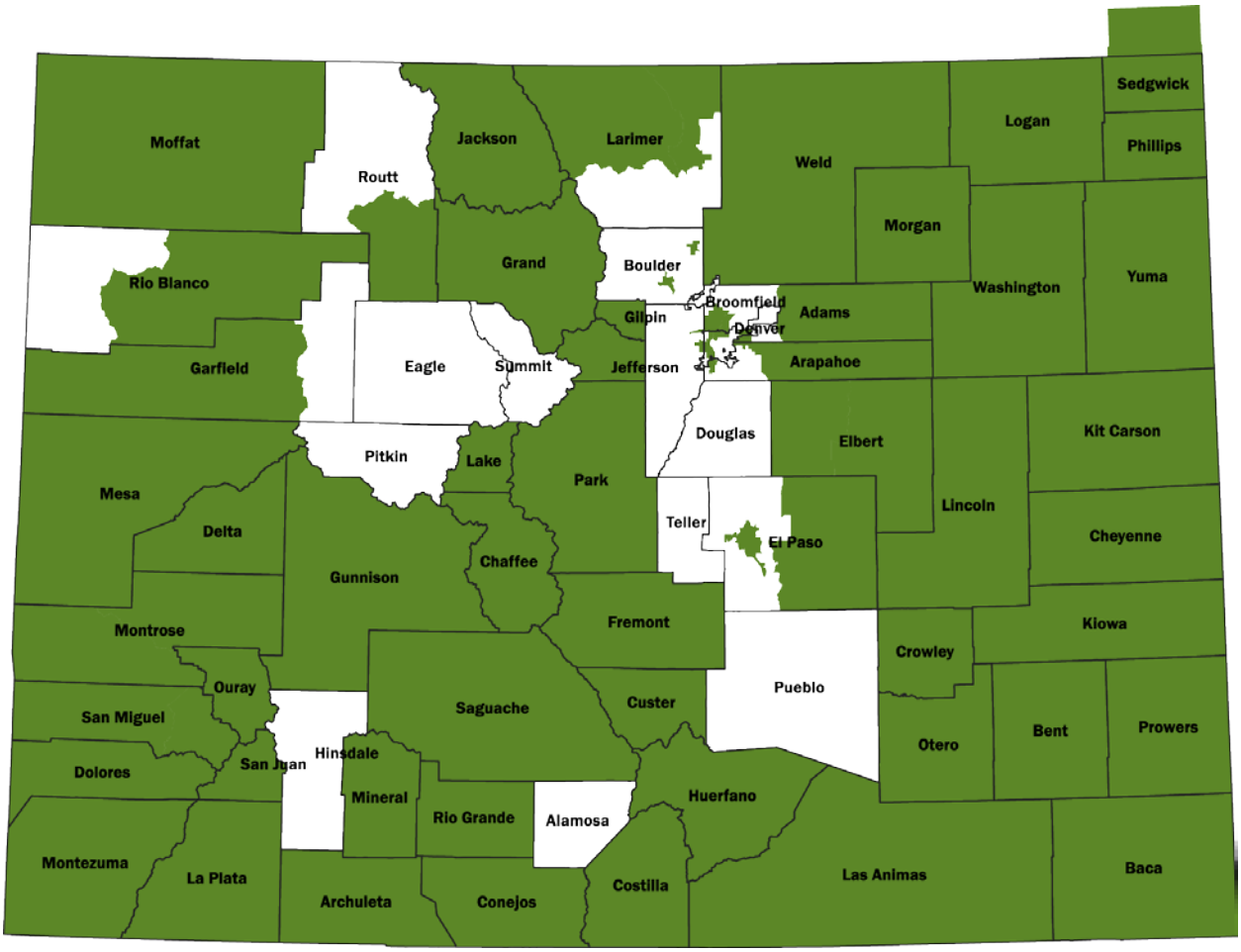
[8] HPSAs are designations that indicate a shortage of primary care, dental or mental health providers in a particular area either for the population as a whole or for a specific population.

[9] MUAs denote areas that have a shortage of primary care health services for residents, while MUPs denote areas that have a shortage of primary care health services for a specific population (such as low-income residents).

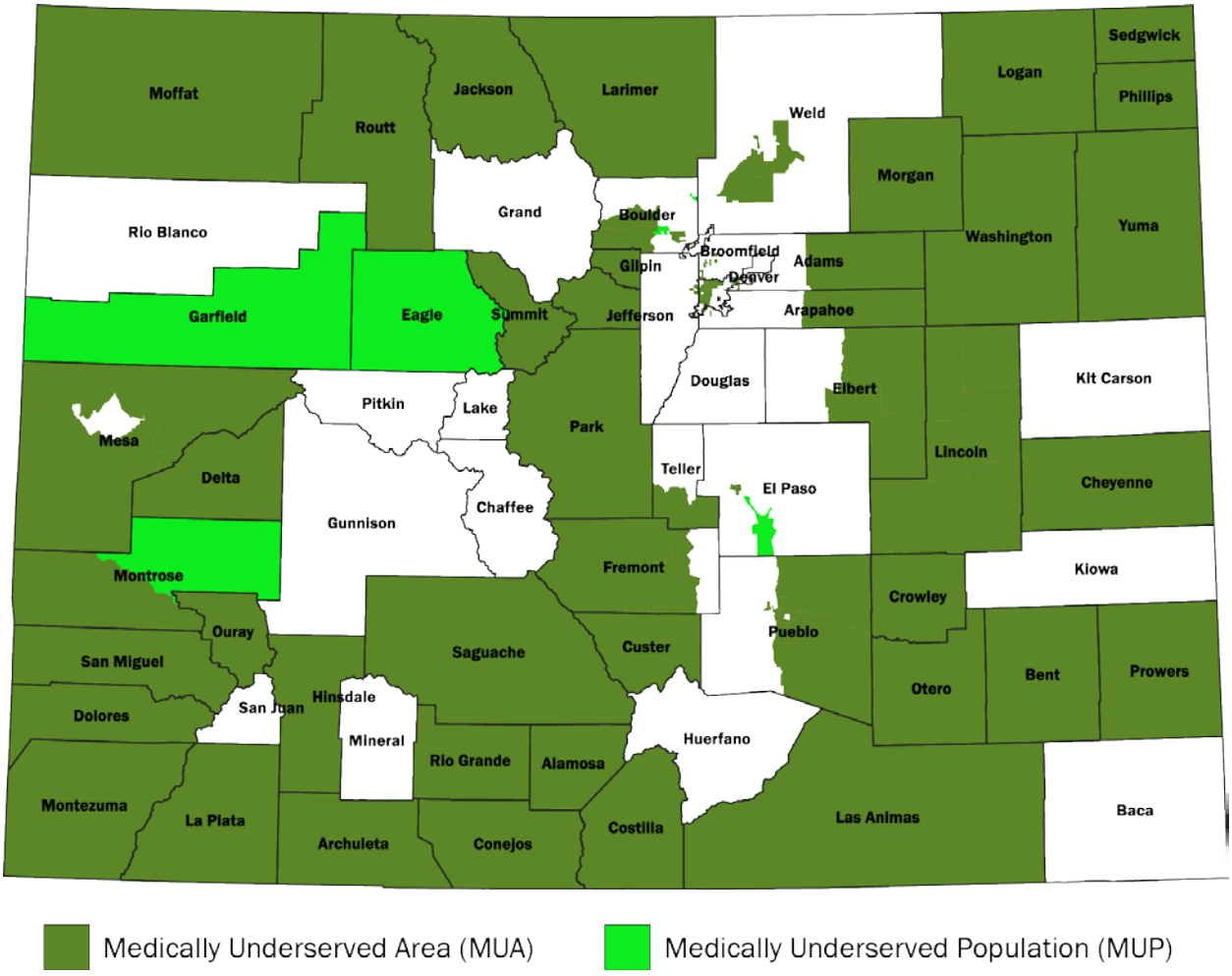
[10] *Snapshot of Rural Health in Colorado 2020*.

Figure 3. HPSAs, MUAs, and MUPs – Colorado

Primary Care Health Professional Shortage Areas



Medically Underserved Areas and Populations



Source: Health Resource and Services Administration, Department of Health and Human Services

Contribution of Health Care to Rural Economies

Beyond the health services provided by FQHCs and RHCs, both types of facilities contribute to the economies of their communities. A 2018 study of 20 Community Health Centers (primarily FQHCs) in both urban and rural Colorado found that these 20 clinics directly created 5,869 jobs and supported an additional 4,673 jobs in their community. They generated $639 million in direct health spending which in turn supported $722 million in community spending for a total economic impact of $1.4 billion. Furthermore, this economic activity generated $51 million in state and local tax revenues.[11] The impact of RHCs and Critical Access Hospitals (CAHs)[12] is even greater. Every physician employed by a RHC or CAH creates approximately 26 additional jobs and nearly $1.4 million in economic activity.[13] Beyond these direct impacts, the health care industry represents one of the top three industries for employment in rural Colorado. Registered nurses are the top occupation in rural

[11] *The Value and Impact of Colorado's Community Health Centers*. Colorado Community Health Network (2018). https://cchn.org/wp-content/uploads/2020/02/2018-Statewide-Value-and-Impact-of-Colorado-CHCs.pdf.

[12] Critical Access Hospitals (CAHs) is a federal designation given to rural hospitals designed to reduce financial vulnerability of rural hospitals and to improve access to health care in rural areas.

[13] *Snapshot of Rural Health in Colorado 2020*.

Colorado.[14] Losing such facilities would not only exacerbate existing access issues present in rural Colorado, but also remove a critical driver of rural economies across the state.

Financial Struggles of Rural Health Facilities

Health facilities in rural areas were struggling to remain financially solvent even before the additional stresses placed on their finances by COVID-19. Eighteen out of forty-two rural hospitals in the state operated with negative profit margins in 2019. The financial situation of rural hospitals and clinics has deteriorated since the outbreak of the COVID-19 pandemic. According to a survey conducted by the Colorado Rural Health Center (CRHC) of its members, over half reported losing revenue due to a significant decrease in patients. Some facilities reported having to pay over three times the regular price for personal protective equipment (PPE) and other supplies. Even more alarming, the survey found that half of respondents had less than 57 days cash on hand to pay for operations, maintenance, employees, and equipment.[15] As summarized by CRHC: "Without immediate and sustained financial support, the outlook for our rural healthcare facilities is bleak this summer and potentially beyond this year. Facilities are preparing to cut staff, services, or even close."[16] While these providers will receive some relief from the CARES Act, this money is strictly for COVID-19-related expenses and it is not clear how freely rural providers can use the funds to cover expenses. A public health emergency is not the time to be proposing additional cuts to in state funding for our health care infrastructure, which will disproportionately affect rural health care facilities. However, without additional revenue through a mechanism such as a TABOR emergency tax, the General Assembly will have no choice but to do exactly this.

Proposed Cuts to Colorado's State Budget

As it became apparent that Colorado's fiscal situation had deteriorated as a result of the COVID-19 pandemic, the Joint Budget Committee Staff released a series of working documents outlining recommendations for cuts in state departments' spending to maintain spending at FY 2019-20 levels. [17] This was before the Legislative Council released their May 2020 forecast indicating the state would face a $3.3 billion revenue shortfall. Since then, the JBC has considered a number of additional cuts, which are noted in the recently introduced Long Appropriations Bill (or Long Bill).[18]

Changes to Health First Colorado and CHP+

Although the JBC proposed budget cuts to Health First Colorado (HFC) programs in the Long Bill, those cuts will not restrict eligibility, reduce current enrollment or eliminate benefits for HFC or CHP+. Enrollment in HFC is expected to rise as a result of job losses seen across the state due to the COVID-19 pandemic. This surge in enrollment is expected to peak in mid-2020 before tapering off for the remainder of the fiscal year. Disenrollments have been suspended for the duration of the declared emergency and are not expected to resume until January 2021. This means that state expenditures on Medicaid will rise; however HCPF expects new enrollees will be healthier and significantly less expensive to cover than the current pool of enrollees.

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[14] *Ibid.*

[15] *COVID-19 and a Looming Rural Health Crisis*.

[16] *Ibid.*

[17] *Revised Staff Budget Balancing FY 2019-20 & FY 2020-21: Department of Health Care Policy and Financing*. Joint Budget Committee (2020). Colorado General Assembly. State of Colorado. https://leg.colorado.gov/sites/default/files/hcpf_bal_fy20-21_05-04-20.pdf

[18] Introduced as HB20-1360 on May 26, 2020.

The federal Families First Coronavirus Relief Act provided for an increased federal match in Medicaid dollars for states that did not reduce enrollment, benefits, or eligibility for Medicaid programs. As a result, the JBC staff estimate the increase in federal funding will offset state costs through December 2020. Mirroring its approach to HFC, HCPF also extended its Maintenance of Eligibility (MOE) for CHP+ for the duration of the public health emergency, meaning enrollment, benefits, and eligibility for this essential program will not be affected. While these are all positive steps for maintaining access to health for Coloradans living in rural areas, other cuts are included in the Long Bill.

Cuts that Would Affect Rural Health Access

A number of cuts to HCPF's budget included in the Long Bill will have a negative effect on Coloradans' ability to access health care, particularly in rural parts of the state. Cuts proposed by the JBC included undoing appropriation decisions made prior to March 2020, as well as new reductions in spending. These include:

- **Reduce Community Provider Rates:** Prior to the pandemic, the JBC had approved a 1.9% common policy increase for community provider rates. Not only was this increase undone by the JBC, reducing General Fund expenditures by $33.6 million, but an across-the-board reduction of 1 percent for most community providers. This reduction reduces General Fund expenditures by an additional $18 million. It does not apply to rates that are based on a methodology defined in statute, such as those for RHCs and FQHCs.

- **Raise Medicaid Member Copays:** The Long Bill proposes to increase copays for Medicaid members to the federally-allowed maximum, reducing General Fund expenditures by $2.1 million. Copays for visits to FQHCs and RHCs would increase from $2.00 to $4.00 under this, reducing General Fund expenditures by a total of $80,731.

- **Transfer of Health Care Affordability and Sustainability (HAS) Fee:** Before the General Assembly's recess in March, the JBC had approved $629.3 million in supplemental payments to Colorado hospitals through the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Fund. The JBC propose to take $161 million of this (approximately 26 percent of the supplemental payments) to offset General Fund expenses.

It is important to reiterate that these are just some of the cuts included in the Long Bill. The JBC proposed additional cuts that would negatively affect the health and well-being of Coloradans, regardless of where they live. These include capping adult dental benefits at a lower level, reducing outreach to families with children in the Healthy Communities program, delaying implementation of the state's residential substance use disorder (SUD) treatment benefit by 6 months; and, due to cuts in the budget for the Colorado Department of Human Services, reductions in behavioral health provider reimbursement and rural SUD treatment capacity.

Impact of Cuts on Rural Health Access

While not specifically targeted to rural health facilities and providers, the cuts included in the Long Bill are likely to have a disproportionate impact on health care in rural areas. Many of the cuts to RHCs and FQHCs were downplayed by JBC staff because they contend the loss of funds can be offset with money received by these facilities through the federal CARES Act. However, these funds come with the condition that they only be used to offset expenses related to the COVID-19 pandemic. It is unclear the extent to which RHCs, FQHCs, and other rural hospitals and health providers can use CARES Act funds to offset reduced state funding or revenue. Unlike hospitals in urban areas, many

rural hospitals have not experienced an influx of COVID-19 patients but have seen sharp declines in demand for services due to the statewide stay-at-home order.

Healthcare Affordability and Sustainability Fee Transfers

Of the cuts discussed above, the one with the greatest potential impact on rural health providers is the transfer of $161 million from the supplemental payments provided to hospitals through the Healthcare Affordability and Sustainability (HAS) fee, also referred to as the provider fee. Fees collected through this program are placed into a fund and then paid back to hospitals based on a number of criteria developed by HCPF and the CHASE Board. In 2019, hospitals throughout Colorado paid over $900 million into this fund and received just under $1.4 billion in supplemental payments for a net benefit to hospitals of over $465 million.[19] Due to the way the supplemental payment amounts are awarded, rural hospitals disproportionately benefit from this program. In 2019, HAS fees collected from rural hospitals accounted for just 7 percent of all fees collected. However, rural hospitals received 15 percent of the supplemental payments paid from the CHASE Fund, a net reimbursement of nearly $140 million. Reducing the supplemental payment for 2020 by $161 million represents a potential 26 percent decrease in funding for rural hospitals at a time when they are already struggling to remain financially solvent. If these cuts go forward, HCPF and the CHASE Board must limit, to the extent possible, the impact they will have on rural hospitals' already strained budgets.

Increased Medicaid Copays

This change will have two impacts on access to health care in rural areas. First, since a larger share of Coloradans in rural areas receive coverage through Health First Colorado than do Coloradans in urban areas, this copay increase will have a disproportionate impact on rural residents. While many of these increases are small, every dollar counts for out-of-work Coloradans who must manage other expenses (such as rent/mortgage payments, food, etc.) and will be seeing an end to the expanded unemployment benefits provided through the CARES Act at the end of July 2020. Second, as noted by JCB staff, providers often consider copay increases as de facto provider rate reductions since those enrolled in Health First Colorado may not pay the increased copay. It is generally more expensive to collect the unpaid additional copay after the fact than it is to just take the loss.

Reduction in Provider Rates

Although this does not apply to reimbursement rates for RHCs or FQHCs, it will impact the ability of other providers in rural areas to provide care to patients covered through Health First Colorado. Most providers are already undercompensated for the care they provide to Health First Colorado patients. According the HCPF's 2020 Cost Shift Analysis, hospital providers in 2018 were only compensated $0.77 for every $1.00 spent on care for Medicaid patients, compared to $1.70 for every $1.00 spent on care for patients with private insurance. Providers that are unable to bear these reduced reimbursements will stop accepting Medicaid patients, potentially reducing provider options for rural Coloradans, 26 percent of whom are covered through Health First Colorado.

Maintaining Changes to Telehealth Reimbursement for RHCs and FQHCs

While not something that was affected by budget cuts included in the Long Bill, this issue will be hard to address given the state's current fiscal situation. During the COVID-19 state of emergency, HCPF authorized RHCs and FQHCs (in addition to Indian Health Services providers) to bill for telehealth visits. Prior to COVID, state rules limited reimbursements to these providers to face-to-face visits only. HCPF's emergency rules also expanded the definition of telemedicine to include phone

[19] The amount paid back to hospitals is greater than the amount collected due to federal matching funds.

calls, critical for rural areas that tend to lack access to computers and/or broadband internet service. However, these new rules will expire at the end of the declared state of emergency. If in-person visits to health care providers continue to be below normal even after the end of the state of emergency, then RHCs and FQHCs are in a potentially dire position of being unable to receive compensation for telemedicine visits despite demand for such services by their patients. Without the source of revenue RHCs and FQHCs receive through payments for in-person visits, many may need to reduce staff, reduce services, or in the worst-case scenario, close. Making these rules permanent would add to General Fund obligations in a time when the state is looking to cut of over $3 billion.

What Can Be Done?

While budget cuts are inevitable given the magnitude of the state's revenue shortfall, cuts do not need to be as severe as currently discussed. Legislators could adopt a three-pronged approach to raise additional revenue to offset the current revenue shortfall. This strategy includes:

- Responsibly drawing down state reserves;
- Continuing to lobby Congress to provide unrestricted aid to states; and
- Passing a temporary emergency tax increase as allowed under TABOR

Not only would an emergency TABOR tax increase state revenue, adopting a progressive tax structure similar to that proposed by Initiative 271 would result in a tax cut for 95 percent of Colorado taxpayers. Not only would this strategy raise revenue for the state, it would also provide taxpayers with additional revenue they can use to pay bills or to help jumpstart our economy through spending in their local communities.