First Regular Session
Seventy-fourth General Assembly
STATE OF COLORADO

REREVISED

This Version Includes All Amendments Adopted in the Second House

LLS NO. 23-0404.01 Brita Darling x2241

HOUSE BILL 23-1215

HOUSE SPONSORSHIP

Sirota and Boesenecker, Bacon, Brown, Epps, Froelich, Gonzales-Gutierrez, Herod, Jodeh, Kipp, Lindsay, Mabrey, Marshall, Ortiz, Sharbini, Valdez, Weissman, Willford

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House Committees	**Senate Committees**
Health & Insurance	Health & Human Services
Appropriations	Appropriations

SENATE
3rd Reading Unamended
May 4, 2023

SENATE
Amended 2nd Reading
May 3, 2023

HOUSE
3rd Reading Unamended
April 18, 2023

HOUSE
Amended 2nd Reading
April 17, 2023

A BILL FOR AN ACT

101 CONCERNING LIMITATIONS ON HOSPITAL FACILITY FEES, AND, IN
102 CONNECTION THEREWITH, MAKING AND REDUCING AN
103 APPROPRIATION.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov.)

The bill defines "health-care provider" as a person that is licensed or otherwise authorized in this state to furnish a health-care service, which includes a hospital and other providers and health facilities.

The bill prohibits a health-care provider (provider) affiliated with or owned by a hospital or health system from charging a facility fee for

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.
Capital letters or bold & italic numbers indicate new material to be added to existing law.
Dashes through the words or numbers indicate deletions from existing law.

health-care services furnished by the provider for:

- Outpatient services provided at an off-campus location or through telehealth; or
- Certain outpatient, diagnostic, or imaging services identified by the medical services board as services that may be provided safely, reliably, and effectively in nonhospital settings.

The bill:

- Requires a provider that charges a facility fee to provide notice to a patient that the provider charges the fee and to use a standardized bill that includes itemized charges identifying the facility fee, as well as other information;
- Requires the administrator of the all-payer health claims database to prepare an annual report of the number and amount of facility fees by payer, codes with the highest total paid amounts and highest volume, and other information; and
- Makes it a deceptive trade practice to charge, bill, or collect a facility fee when doing so is prohibited.

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1 *Be it enacted by the General Assembly of the State of Colorado:*

2 **SECTION 1.** In Colorado Revised Statutes, **add** 6-20-102 as
3 follows:

4 **6-20-102. Limits on facility fees - rules - definitions.**
5 (1) **Definitions.** AS USED IN THIS SECTION, UNLESS THE CONTEXT
6 OTHERWISE REQUIRES:

7 (a) "AFFILIATED WITH" MEANS:

8 (I) EMPLOYED BY A HOSPITAL OR HEALTH SYSTEM; OR

9 (II) UNDER A PROFESSIONAL SERVICES AGREEMENT, FACULTY
10 AGREEMENT, OR MANAGEMENT AGREEMENT WITH A HOSPITAL OR HEALTH
11 SYSTEM THAT PERMITS THE HOSPITAL OR HEALTH SYSTEM TO BILL ON
12 BEHALF OF THE AFFILIATED ENTITY.

13 (b) "CAMPUS" MEANS:

14 (I) A HOSPITAL'S MAIN BUILDINGS;

1 (II) THE PHYSICAL AREA IMMEDIATELY ADJACENT TO A HOSPITAL'S
2 MAIN BUILDINGS AND STRUCTURES OWNED BY THE HOSPITAL THAT ARE
3 NOT STRICTLY CONTIGUOUS TO THE MAIN BUILDINGS BUT ARE LOCATED
4 WITHIN TWO HUNDRED FIFTY YARDS OF THE MAIN BUILDINGS; OR
5 (III) ANY OTHER AREA THAT THE FEDERAL CENTERS FOR
6 MEDICARE AND MEDICAID SERVICES IN THE UNITED STATES DEPARTMENT
7 OF HEALTH AND HUMAN SERVICES HAS DETERMINED, ON AN
8 INDIVIDUAL-CASE BASIS, TO BE PART OF A HOSPITAL'S CAMPUS.
9 (c) "CRITICAL ACCESS HOSPITAL" MEANS A HOSPITAL THAT IS
10 FEDERALLY CERTIFIED OR UNDERGOING FEDERAL CERTIFICATION AS A
11 CRITICAL ACCESS HOSPITAL PURSUANT TO 42 CFR 485, SUBPART F.
12 (d) "FACILITY FEE" MEANS ANY FEE A HOSPITAL OR HEALTH
13 SYSTEM CHARGES OR BILLS FOR OUTPATIENT HOSPITAL SERVICES THAT IS:
14
15 (I) INTENDED TO COMPENSATE THE HOSPITAL OR HEALTH SYSTEM
16 FOR ITS OPERATIONAL EXPENSES; AND
17 (II) SEPARATE AND DISTINCT FROM A PROFESSIONAL FEE CHARGED
18 OR BILLED BY A HEALTH-CARE PROVIDER FOR PROFESSIONAL MEDICAL
19 SERVICES.
20 (e) "FREESTANDING EMERGENCY DEPARTMENT" MEANS A HEALTH
21 FACILITY AS DEFINED IN AND REQUIRED TO BE LICENSED UNDER SECTION
22 25-1.5-114.
23 (f) "HEALTH-CARE PROVIDER" MEANS ANY PERSON, INCLUDING A
24 HEALTH FACILITY, THAT IS LICENSED OR OTHERWISE AUTHORIZED IN THIS
25 STATE TO FURNISH A HEALTH-CARE SERVICE.
26 (g) "HEALTH-CARE SERVICE" HAS THE MEANING SET FORTH IN
27 SECTION 10-16-102 (33).

1 (h) "HEALTH FACILITY" MEANS A FACILITY LICENSED OR CERTIFIED
2 PURSUANT TO SECTION 25-1.5-103 OR ESTABLISHED PURSUANT TO PART
3 5 OF ARTICLE 21 OF TITLE 23 OR ARTICLE 29 OF TITLE 25.
4 (i) "HEALTH SYSTEM" HAS THE MEANING SET FORTH IN SECTION
5 10-16-1303 (9).
6 (j) "HOSPITAL" MEANS A HOSPITAL CURRENTLY LICENSED OR
7 CERTIFIED BY THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT
8 PURSUANT TO THE DEPARTMENT'S AUTHORITY UNDER SECTION 25-1.5-103
9 (1)(a) OR ESTABLISHED PURSUANT TO PART 5 OF ARTICLE 21 OF TITLE 23
10 OR ARTICLE 29 OF TITLE 25.
11
12 (k) "MEDICARE" MEANS THE "HEALTH INSURANCE FOR THE AGED
13 ACT", TITLE XVIII OF THE FEDERAL "SOCIAL SECURITY ACT", AS
14 AMENDED BY THE SOCIAL SECURITY AMENDMENTS OF 1965, AND AS LATER
15 AMENDED.
16 (l) "OFF-CAMPUS LOCATION" HAS THE MEANING SET FORTH IN
17 SECTION 25-3-118.
18 (m) "OWNED BY" MEANS OWNED BY A HOSPITAL OR HEALTH
19 SYSTEM WHEN BILLED UNDER THE HOSPITAL'S TAX IDENTIFICATION
20 NUMBER.
21 (n) "PAYER TYPE" MEANS COMMERCIAL INSURERS; MEDICARE; THE
22 MEDICAL ASSISTANCE PROGRAM ESTABLISHED PURSUANT TO ARTICLES 4
23 TO 6 OF TITLE 25.5; INDIVIDUALS WHO SELF-PAY; A FINANCIAL ASSISTANCE
24 PLAN; OR THE "COLORADO INDIGENT CARE PROGRAM", ESTABLISHED IN
25 PART 1 OF ARTICLE 3 OF TITLE 25.5.
26 (o) "SOLE COMMUNITY HOSPITAL" HAS THE MEANING SET FORTH
27 IN 42 CFR 412.92.

(2) **Limitations on charges.** (a) ON AND AFTER JULY 1, 2024, A HEALTH-CARE PROVIDER OR HEALTH SYSTEM SHALL NOT CHARGE, BILL, OR COLLECT A FACILITY FEE DIRECTLY FROM A PATIENT THAT IS NOT COVERED BY A PATIENT'S INSURANCE FOR PREVENTIVE HEALTH-CARE SERVICES, AS DESCRIBED IN SECTION 10-16-104 (18), THAT ARE PROVIDED IN AN OUTPATIENT SETTING.

(b) THIS SUBSECTION (2) DOES NOT PROHIBIT A HEALTH-CARE PROVIDER FROM CHARGING A FACILITY FEE FOR:

(I) HEALTH-CARE SERVICES PROVIDED IN AN INPATIENT SETTING;

(II) HEALTH-CARE SERVICES PROVIDED AT A HEALTH FACILITY THAT INCLUDES A LICENSED HOSPITAL EMERGENCY DEPARTMENT; OR

(III) EMERGENCY SERVICES PROVIDED AT A LICENSED FREESTANDING EMERGENCY DEPARTMENT.

(c) NOTHING IN THIS SUBSECTION (2) PROHIBITS A HEALTH-CARE PROVIDER OR HEALTH SYSTEM FROM CHARGING, BILLING, OR COLLECTING A FACILITY FEE FROM A PATIENT'S INSURER PURSUANT TO AN AGREEMENT BETWEEN THE HEALTH-CARE PROVIDER OR HEALTH SYSTEM AND THE CARRIER OR AS REQUIRED BY LAW.

(3) **Transparency.** (a) ON AND AFTER JULY 1, 2024, A HEALTH-CARE PROVIDER AFFILIATED WITH OR OWNED BY A HOSPITAL OR HEALTH SYSTEM THAT CHARGES A FACILITY FEE SHALL:

(I) (A) PROVIDE NOTICE IN PLAIN LANGUAGE TO PATIENTS THAT A FACILITY FEE MAY BE CHARGED, INDICATE IN THE NOTICE THE AMOUNT OF THE FACILITY FEE, AND REQUIRE THE HEALTH-CARE PROVIDER TO PROVIDE THE NOTICE TO A PATIENT AT THE TIME AN APPOINTMENT IS SCHEDULED

1 AND AGAIN AT THE TIME THE HEALTH-CARE SERVICES ARE RENDERED; AND
2 (B) POST A SIGN, IN ENGLISH AND SPANISH AND THAT IS PLAINLY
3 VISIBLE AND LOCATED IN THE AREA WITHIN THE HEALTH FACILITY WHERE
4 AN INDIVIDUAL SEEKING CARE REGISTERS OR CHECKS IN, THAT STATES
5 THAT THE PATIENT MAY BE CHARGED A FACILITY FEE IN ADDITION TO THE
6 COST OF THE HEALTH-CARE SERVICE. THE SIGN MUST ALSO INCLUDE A
7 LOCATION WITHIN THE HEALTH FACILITY WHERE A PATIENT MAY INQUIRE
8 ABOUT FACILITY FEES AND AN ONLINE LOCATION WHERE INFORMATION
9 ABOUT FACILITY FEES MAY BE FOUND.
10 (II) PROVIDE TO A PATIENT A STANDARDIZED BILL THAT:
11 (A) INCLUDES ITEMIZED CHARGES FOR EACH HEALTH-CARE
12 SERVICE;
13 (B) SPECIFICALLY IDENTIFIES ANY FACILITY FEE;
14 (C) IDENTIFIES SPECIFIC CHARGES THAT HAVE BEEN BILLED TO
15 INSURANCE OR OTHER PAYER TYPES FOR HEALTH-CARE SERVICES; AND
16 (D) INCLUDES CONTACT INFORMATION FOR FILING AN APPEAL WITH
17 THE HEALTH-CARE PROVIDER TO CONTEST CHARGES.
18 (b) THE HEALTH-CARE PROVIDER SHALL PROVIDE THE REQUIRED
19 NOTICE AND STANDARDIZED BILL IN A CLEAR MANNER AND, TO THE
20 EXTENT PRACTICABLE, IN THE PATIENT'S PREFERRED LANGUAGE.
21 (c) (I) A HEALTH FACILITY THAT IS NEWLY AFFILIATED WITH OR
22 OWNED BY A HOSPITAL OR HEALTH SYSTEM ON OR AFTER JULY 1, 2024,
23 SHALL PROVIDE WRITTEN NOTICE TO EACH PATIENT RECEIVING SERVICES
24 WITHIN THE TWELVE-MONTH PERIOD IMMEDIATELY PRECEDING THE
25 AFFILIATION OR CHANGE OF OWNERSHIP THAT THE HEALTH FACILITY IS
26 PART OF A HOSPITAL OR HEALTH SYSTEM. THE NOTICE MUST INCLUDE:
27 (A) THE NAME, BUSINESS ADDRESS, AND PHONE NUMBER OF THE

1 HOSPITAL OR HEALTH SYSTEM THAT IS THE PURCHASER OF THE HEALTH
2 FACILITY OR WITH WHOM HEALTH FACILITY IS AFFILIATED;
3 (B) A STATEMENT THAT THE HEALTH FACILITY BILLS, OR IS LIKELY
4 TO BILL, PATIENTS A FACILITY FEE THAT MAY BE IN ADDITION TO AND
5 SEPARATE FROM ANY PROFESSIONAL FEE BILLED BY A HEALTH-CARE
6 PROVIDER AT THE HEALTH FACILITY; AND
7 (C) A STATEMENT THAT, PRIOR TO SEEKING SERVICES AT THE
8 HEALTH FACILITY, A PATIENT COVERED BY A HEALTH INSURANCE POLICY
9 OR HEALTH BENEFIT PLAN SHOULD CONTACT THE PATIENT'S HEALTH
10 INSURER FOR ADDITIONAL INFORMATION REGARDING THE HEALTH
11 FACILITY'S FACILITY FEES, INCLUDING THE PATIENT'S POTENTIAL
12 FINANCIAL LIABILITY, IF ANY, FOR THE FACILITY FEES.
13 (II) A HOSPITAL, HEALTH SYSTEM, OR HEALTH FACILITY SHALL NOT
14 COLLECT A FACILITY FEE FOR HEALTH-CARE SERVICES PROVIDED BY A
15 HEALTH-CARE PROVIDER AFFILIATED WITH OR OWNED BY A HOSPITAL OR
16 HEALTH SYSTEM THAT IS SUBJECT TO ANY PROVISIONS OF THIS SECTION
17 FROM THE DATE OF THE TRANSACTION UNTIL AT LEAST THIRTY DAYS
18 AFTER THE WRITTEN NOTICE REQUIRED PURSUANT TO THIS SUBSECTION
19 (3)(c)(I) IS MAILED TO THE PATIENT.
20 (4) SUBSECTION (2) OF THIS SECTION DOES NOT APPLY TO A
21 CRITICAL ACCESS HOSPITAL, A SOLE COMMUNITY HOSPITAL IN A RURAL OR
22 FRONTIER AREA, OR A COMMUNITY CLINIC AFFILIATED WITH A SOLE
23 COMMUNITY HOSPITAL IN A RURAL OR FRONTIER AREA.
24 (5) SUBSECTION (2) OF THIS SECTION DOES NOT APPLY TO A
25 HOSPITAL ESTABLISHED PURSUANT TO ARTICLE 29 OF TITLE 25.
26 **SECTION 2.** In Colorado Revised Statutes, **add** 10-16-158 as
27 follows:

1 **10-16-158. Hospital facility fee report - data collection.** THE
2 COMMISSIONER IS AUTHORIZED TO COLLECT FROM A CARRIER OFFERING A
3 HEALTH BENEFIT PLAN INFORMATION SPECIFIED IN SECTION 25.5-4-216, IF
4 AVAILABLE, FOR PURPOSES OF FACILITATING THE DEVELOPMENT OF THE
5 REPORT RELATING TO FACILITY FEES.
6
7 **SECTION 3.** In Colorado Revised Statutes, 6-1-105, **add**
8 (1)(uuu) as follows:
9 **6-1-105. Unfair or deceptive trade practices.** (1) A person
10 engages in a deceptive trade practice when, in the course of the person's
11 business, vocation, or occupation, the person:
12 (uuu) CHARGES, BILLS, OR COLLECTS A FACILITY FEE OR FAILS TO
13 COMPLY WITH OTHER PROVISIONS RELATING TO FACILITY FEES IN
14 VIOLATION OF SECTION 6-20-102 (2) OR (3).
15 **SECTION 4.** In Colorado Revised Statutes, **add** 25.5-4-216 as
16 follows:
17 **25.5-4-216. Report on impact of hospital facility fees in**
18 **Colorado - definitions - steering committee - repeal.** (1) AS USED IN
19 THIS SECTION:
20 (a) "AFFILIATED WITH" HAS THE MEANING SET FORTH IN SECTION
21 6-20-102 (1)(a).
22 (b) "CAMPUS" HAS THE SAME MEANING SET FORTH IN SECTION
23 6-20-102 (1)(b).
24 (c) "CPT CODE" HAS THE MEANING SET FORTH IN SECTION
25 25.5-1-204.7 (1)(d).
26 (d) "FACILITY FEE" HAS THE MEANING SET FORTH IN SECTION
27 6-20-102 (1)(d).

1 (e) "HEALTH-CARE PROVIDER" HAS THE MEANING SET FORTH IN
2 SECTION 6-20-102 (1)(f).
3 (f) "HEALTH SYSTEM" HAS THE MEANING SET FORTH IN SECTION
4 10-16-1303 (9).
5 (g) "HOSPITAL" HAS THE MEANING SET FORTH IN SECTION 6-20-102
6 (1)(j).
7 (h) "OWNED BY" HAS THE MEANING SET FORTH IN SECTION
8 6-20-102 (1)(m).
9 (i) "PAYER TYPE" HAS THE MEANING SET FORTH IN SECTION
10 6-20-102 (1)(n).
11 (j) "STEERING COMMITTEE" MEANS THE STEERING COMMITTEE
12 CREATED IN SUBSECTION (2) OF THIS SECTION.
13 (2) THERE IS CREATED IN THE STATE DEPARTMENT A STEERING
14 COMMITTEE TO RESEARCH AND REPORT ON THE IMPACT OF OUTPATIENT
15 FACILITY FEES. THE STEERING COMMITTEE CONSISTS OF THE FOLLOWING
16 SEVEN MEMBERS APPOINTED BY THE GOVERNOR WITH RELEVANT
17 EXPERTISE IN HEALTH-CARE BILLING AND PAYMENT POLICY:
18 (a) TWO MEMBERS REPRESENTING HEALTH-CARE CONSUMERS,
19 WITH AT LEAST ONE OF THE MEMBERS REPRESENTING A HEALTH-CARE
20 CONSUMER ADVOCACY ORGANIZATION;
21 (b) ONE MEMBER REPRESENTING A HEALTH-CARE PAYER OR
22 PAYERS;
23 (c) ONE MEMBER REPRESENTING HEALTH-CARE PROVIDERS NOT
24 AFFILIATED WITH OR OWNED BY A HOSPITAL OR HEALTH SYSTEM OR WHO
25 HAS INDEPENDENT PHYSICIAN BILLING EXPERTISE;
26 (d) ONE MEMBER REPRESENTING A STATEWIDE ASSOCIATION OF
27 HOSPITALS;

1 (e) ONE MEMBER REPRESENTING A RURAL, CRITICAL ACCESS OR
2 INDEPENDENT HOSPITAL; AND
3 (f) THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HEALTH
4 CARE POLICY AND FINANCING, OR THE EXECUTIVE DIRECTOR'S DESIGNEE.
5 (3) (a) THE STEERING COMMITTEE SHALL FACILITATE THE
6 DEVELOPMENT OF A REPORT DETAILING THE IMPACT OF OUTPATIENT
7 FACILITY FEES ON THE COLORADO HEALTH-CARE SYSTEM, INCLUDING THE
8 IMPACT ON CONSUMERS, EMPLOYERS, HEALTH-CARE PROVIDERS, AND
9 HOSPITALS. IN DEVELOPING VARIOUS ASPECTS OF THE REPORT REQUIRED
10 IN THIS SECTION, THE STEERING COMMITTEE SHALL WORK WITH
11 INDEPENDENT THIRD PARTIES TO CONDUCT RELATED RESEARCH AND
12 ANALYSIS NECESSARY TO IDENTIFY AND EVALUATE THE IMPACT OF
13 OUTPATIENT FACILITY FEES.
14 (b) THE STEERING COMMITTEE SHALL PREPARE A PRELIMINARY
15 VERSION OF THE REPORT ON OR BEFORE AUGUST 1, 2024, UNLESS MORE
16 TIME IS REQUIRED, AND A FINAL REPORT PREPARED ON OR BEFORE
17 OCTOBER 1, 2024, THAT MUST BE SUBMITTED TO THE HOUSE OF
18 REPRESENTATIVES HEALTH AND INSURANCE COMMITTEE AND THE SENATE
19 HEALTH AND HUMAN SERVICES COMMITTEE, OR THEIR SUCCESSOR
20 COMMITTEES.
21 (4) (a) FOR PURPOSES OF DEVELOPING THE REPORT, THE STEERING
22 COMMITTEE, WITH ADMINISTRATIVE SUPPORT FROM THE STATE
23 DEPARTMENT, MAY:
24 (I) SELECT THIRD-PARTY CONTRACTORS TO ASSIST IN
25 RESEARCHING AND CREATING THE REPORT, WITH AN APPROPRIATION MADE
26 TO THE STATE DEPARTMENT FOR SUCH PURPOSE;
27 (II) DEVELOP THE FORMAT, SCOPE, AND TEMPLATES FOR REQUESTS

1 FOR INFORMATION;

2 (III) REVIEW DRAFTS, PROVIDE FEEDBACK, AND FINALIZE THE

3 REPORT;

4 (IV) ANSWER TECHNICAL QUESTIONS FROM THIRD-PARTY

5 CONTRACTORS; AND

6 (V) CONSULT WITH EXTERNAL STAKEHOLDERS.

7 (b) THE STEERING COMMITTEE, STATE DEPARTMENT, AND ANY

8 THIRD-PARTY CONTRACTORS ENGAGED IN THE DEVELOPMENT OF THE

9 REPORT ARE ENCOURAGED TO USE BOTH PRIMARY AND SECONDARY

10 SOURCES AND RESEARCH, WHERE POSSIBLE, AND, TO THE EXTENT

11 FEASIBLE, ENSURE THE REPORT IS WELL-INFORMED BY THE PERSPECTIVES

12 OF DIVERSE STAKEHOLDERS. THE STEERING COMMITTEE SHALL WORK

13 ONLY WITH THIRD-PARTY CONTRACTORS THAT ARE ALREADY APPROVED

14 AS ONE OF THE STATE DEPARTMENT'S PROJECT-BASED CONTRACTS.

15 (c) TO THE EXTENT PRACTICABLE, EVALUATION AND ANALYSIS

16 PERFORMED FOR THE REPORT MUST ATTEMPT TO LEVERAGE

17 COLORADO-SPECIFIC DATA SOURCES AND PUBLICLY AVAILABLE NATIONAL

18 DATA AND RESEARCH.

19 (5) THE REPORT MUST IDENTIFY AND EVALUATE:

20 (a) PAYER REIMBURSEMENT AND PAYMENT POLICIES FOR

21 OUTPATIENT FACILITY FEES ACROSS PAYER TYPES, INCLUDING INSIGHTS,

22 WHERE AVAILABLE, INTO CHANGES OVER TIME, AS WELL AS PROVIDER

23 BILLING GUIDELINES AND PRACTICES FOR OUTPATIENT FACILITY FEES

24 ACROSS PROVIDER TYPES, INCLUDING INSIGHTS, WHERE AVAILABLE, INTO

25 CHANGES MADE OVER TIME;

26 (b) PAYMENTS FOR OUTPATIENT FACILITY FEES, INCLUDING

27 INSIGHTS INTO THE ASSOCIATED CARE ACROSS PAYER TYPES;

1 (c) COVERAGE AND COST-SHARING PROVISIONS FOR OUTPATIENT
2 CARE SERVICES ASSOCIATED WITH FACILITY FEES ACROSS PAYERS AND
3 PAYER TYPES;
4 (d) DENIED FACILITY FEE CLAIMS BY PAYER TYPE AND PROVIDER
5 TYPE;
6 (e) THE IMPACT OF FACILITY FEES AND PAYER COVERAGE POLICIES
7 ON CONSUMERS, SMALL AND LARGE EMPLOYERS, AND THE MEDICAL
8 ASSISTANCE PROGRAM;
9 (f) THE IMPACT OF FACILITY FEES AND PAYER COVERAGE POLICIES
10 ON THE CHARGES FOR HEALTH-CARE SERVICES RENDERED BY
11 INDEPENDENT HEALTH-CARE PROVIDERS, INCLUDING A COMPARISON OF
12 PROFESSIONAL FEE CHARGES AND FACILITY FEE CHARGES; AND
13 (g) THE CHARGES FOR HEALTH-CARE SERVICES RENDERED BY
14 HEALTH-CARE PROVIDERS AFFILIATED WITH OR OWNED BY A HOSPITAL OR
15 HEALTH SYSTEM, AND INCLUDING A COMPARISON OF PROFESSIONAL FEE
16 AND FACILITY FEE CHARGES.
17 (6) THE REPORT MUST INCLUDE AN ANALYSIS OF:
18 (a) DATA FROM THE COLORADO ALL-PAYER HEALTH CLAIMS
19 DATABASE AS REPORTED UNDER DSG14, INCLUDING, AT A MINIMUM:
20 (I) THE NUMBER OF PATIENT VISITS FOR WHICH FACILITY FEES
21 WERE CHARGED, INCLUDING, TO THE EXTENT POSSIBLE, A BREAKDOWN OF
22 WHICH VISITS WERE IN-NETWORK AND WHICH WERE OUT-OF-NETWORK;
23 (II) TO THE EXTENT POSSIBLE, THE NUMBER OF PATIENT VISITS FOR
24 WHICH THE FACILITY FEES WERE CHARGED OUT-OF-NETWORK AND THE
25 PROFESSIONAL FEES WERE CHARGED IN-NETWORK FOR THE SAME
26 OUTPATIENT SERVICE;
27 (III) THE TOTAL ALLOWED FACILITY FEE AMOUNTS BILLED AND

1 DENIED;

2 (IV) THE TOP TEN MOST FREQUENT CPT CODES, REVENUE CODES,
3 OR COMBINATION THEREOF, AT THE STEERING COMMITTEE'S DISCRETION,
4 FOR WHICH FACILITY FEES WERE CHARGED;

5 (V) THE TOP TEN CPT CODES, REVENUE CODES, OR COMBINATION
6 THEREOF, AT THE STEERING COMMITTEE'S DISCRETION, WITH THE HIGHEST
7 TOTAL ALLOWED AMOUNTS FROM FACILITY FEES;

8 (VI) THE TOP TEN CPT CODES, REVENUE CODES, OR COMBINATION
9 THEREOF, AT THE STEERING COMMITTEE'S DISCRETION, FOR WHICH
10 FACILITY FEES ARE CHARGED WITH THE HIGHEST MEMBER COST SHARING;
11 AND

12 (VII) THE TOTAL NUMBER OF FACILITY FEE CLAIM DENIALS, BY
13 SITE OF SERVICE;

14 (b) DATA FROM HOSPITALS AND HEALTH SYSTEMS, WHICH DATA
15 SHALL BE PROVIDED TO THE STEERING COMMITTEE, INCLUDING:

16 (I) THE NUMBER OF PATIENT VISITS FOR WHICH FACILITY FEES
17 WERE CHARGED;

18 (II) THE TOTAL REVENUE COLLECTED IN FACILITY FEES;

19 (III) A DESCRIPTION OF THE MOST FREQUENT HEALTH-CARE
20 SERVICES FOR WHICH FACILITY FEES WERE CHARGED AND NET REVENUE
21 RECEIVED FOR EACH SUCH SERVICE; AND

22 (IV) A DESCRIPTION OF HEALTH-CARE SERVICES THAT GENERATED
23 THE GREATEST AMOUNT OF GROSS FACILITY FEE REVENUE AND NET
24 REVENUE RECEIVED FOR EACH SUCH SERVICE; AND

25 (V) DATA FROM OFF-CAMPUS HEALTH-CARE PROVIDERS THAT ARE
26 AFFILIATED WITH OR OWNED BY A HOSPITAL OR HEALTH SYSTEM,
27 INCLUDING:

1 (A) HISTORIC AND CURRENT BUSINESS NAMES AND ADDRESSES;
2 (B) HISTORIC AND CURRENT TAX IDENTIFICATION NUMBERS AND
3 NATIONAL PROVIDER IDENTIFIERS;
4 (C) HEALTH-CARE PROVIDER ACQUISITION OR AFFILIATION DATE;
5 (D) FACILITY FEE BILLING POLICIES, INCLUDING WHETHER ANY
6 CHANGES WERE MADE TO SUCH POLICIES BEFORE OR AFTER THE
7 ACQUISITION OR AFFILIATION DATE; AND
8 (E) THE TOP TEN CPT CODES, REVENUE CODES, OR COMBINATION
9 THEREOF, AT THE STATE DEPARTMENT'S DISCRETION, FOR WHICH A
10 FACILITY FEE IS BILLED AND THE PROFESSIONAL FEE AMOUNT FOR THE
11 SAME SERVICE;
12 (c) DATA, IF AVAILABLE, FROM THE STATE DEPARTMENT, THE
13 DIVISION OF INSURANCE, AND COMMERCIAL PAYERS, INCLUDING:
14 (I) THE PAYMENT POLICY EACH PAYER USES FOR PAYMENT OF
15 FACILITY FEES FOR NETWORK PRODUCTS, INCLUDING ANY CHANGES THAT
16 WERE MADE TO SUCH POLICIES WITHIN THE LAST FIVE YEARS;
17 (II) A LIST OF COMMON PROCEDURES ASSOCIATED WITH FACILITY
18 FEES;
19 (III) EACH PAYER'S NETWORK PRODUCT NAMES;
20 (IV) PAID AGGREGATE FACILITY FEE BILLINGS FROM OUTPATIENT
21 PROVIDERS AND THE ASSOCIATED NUMBER OF FACILITY FEE CLAIMS,
22 BROKEN DOWN BY HOSPITAL OR HEALTH SYSTEM; AND
23 (V) A DESCRIPTION OF THE ESTIMATED IMPACT OF FACILITY FEES
24 ON PREMIUM RATES, OUT-OF-NETWORK CLAIMS, MEMBER COST SHARING,
25 AND EMPLOYER COSTS;
26 (d) DATA FROM INDEPENDENT HEALTH-CARE PROVIDERS THAT ARE
27 NOT AFFILIATED WITH OR OWNED BY A HOSPITAL OR HEALTH SYSTEM,

1 INCLUDING:

2 (I) HISTORIC AND CURRENT BUSINESS NAMES AND ADDRESSES;

3 (II) HISTORIC AND CURRENT TAX IDENTIFICATION NUMBERS AND

4 NATIONAL PROVIDER IDENTIFIERS;

5 (III) FACILITY FEE BILLING POLICIES, INCLUDING WHETHER ANY

6 CHANGES WERE MADE TO SUCH POLICIES IN THE PAST FIVE YEARS; AND

7 (IV) WHERE APPLICABLE, THE TOP TEN CPT CODES, REVENUE

8 CODES, OR COMBINATION THEREOF, AT THE STEERING COMMITTEE'S

9 DISCRETION, FOR WHICH A FACILITY FEE IS BILLED AND THE PROFESSIONAL

10 FEE AMOUNT FOR THE SAME SERVICE;

11 (e) THE IMPACT OF FACILITY FEES AND PAYER COVERAGE POLICIES

12 ON THE COLORADO HEALTHCARE AFFORDABILITY AND SUSTAINABILITY

13 ENTERPRISE, CREATED IN SECTION 25.5-4-402.4, THE MEDICAID

14 EXPANSION, UNCOMPENSATED CARE, AND UNDERCOMPENSATED CARE;

15 (f) THE IMPACT OF FACILITY FEES ON ACCESS TO CARE, INCLUDING

16 SPECIALTY CARE, PRIMARY CARE, AND BEHAVIORAL HEALTH CARE;

17 INTEGRATED CARE SYSTEMS; HEALTH EQUITY; AND THE HEALTH-CARE

18 WORKFORCE; AND

19 (g) A DESCRIPTION OF THE WAY IN WHICH HEALTH-CARE

20 PROVIDERS MAY BE PAID OR REIMBURSED BY PAYERS FOR OUTPATIENT

21 HEALTH-CARE SERVICES, WITH OR WITHOUT FACILITY FEES, THAT

22 EXPLORES ANY LEGAL AND HISTORICAL REASONS FOR SPLIT BILLING

23 BETWEEN PROFESSIONAL AND FACILITY FEES AT:

24 (I) ON-CAMPUS LOCATIONS;

25 (II) OFF-CAMPUS LOCATIONS BY HEALTH-CARE PROVIDERS

26 AFFILIATED WITH OR OWNED BY A HOSPITAL OR HEALTH SYSTEM; AND

27 (III) LOCATIONS BY INDEPENDENT HEALTH-CARE PROVIDERS NOT

1 AFFILIATED WITH OR OWNED BY A HOSPITAL SYSTEM.

2 (7) TO THE EXTENT FEASIBLE, DATA ANALYZED FOR PURPOSES OF
3 SUBSECTION (6) OF THIS SECTION MUST BE SOURCED FROM 2014 THROUGH
4 2022, AS DETERMINED BY THE STEERING COMMITTEE AND THIRD-PARTY
5 CONTRACTORS, AND SHALL BE DISAGGREGATED BY:

6 (a) YEAR;

7 (b) HOSPITAL OR HEALTH SYSTEM, WHERE APPLICABLE;

8 (c) TYPE OF SERVICE;

9 (d) FACILITY SITE TYPE, INCLUDING ON OR OFF CAMPUS; AND

10 (e) PAYER.

11 (8) THE STEERING COMMITTEE MAY INCLUDE IN THE REPORT
12 INFORMATION RECEIVED IN ACCORDANCE WITH THIS SECTION; EXCEPT
13 THAT THE STEERING COMMITTEE SHALL NOT SHARE PUBLICLY ANY
14 INFORMATION SUBMITTED TO THE STEERING COMMITTEE THAT IS
15 CONFIDENTIAL, IS PROPRIETARY, CONTAINS TRADE SECRETS, OR IS NOT A
16 PUBLIC RECORD PURSUANT TO PART 2 OF ARTICLE 72 OF TITLE 24 EXCEPT
17 IN AGGREGATED AND DE-IDENTIFIED FORM.

18 (9) THE DATA DESCRIBED IN THIS SECTION MUST BE SOUGHT IN A
19 FORM AND MANNER DETERMINED BY THE STEERING COMMITTEE, STATE
20 DEPARTMENT, OR THIRD-PARTY CONTRACTORS TO FACILITATE SUBMISSION
21 OF INFORMATION. THE STEERING COMMITTEE SHALL SEEK TO EXHAUST
22 EXISTING DATA SOURCES BEFORE MAKING ADDITIONAL REQUESTS FOR
23 INFORMATION FOR PURPOSES OF THE REPORT, AND EVERY EFFORT MUST BE
24 MADE TO MINIMIZE THE NUMBER OF DATA REQUESTS. THE REPORT MUST
25 INCLUDE A DESCRIPTION OF WHICH ENTITIES WERE CONTACTED FOR
26 INFORMATION AND THE OUTCOME OF EACH REQUEST.

27 (10) A STATEWIDE ASSOCIATION OF HOSPITALS MAY ALSO PROVIDE

1 DATA SPECIFIED IN SUBSECTION (6)(b) OF THIS SECTION TO THE STEERING
2 COMMITTEE.
3 (11) THIS SECTION IS REPEALED, EFFECTIVE JANUARY 1, 2025.
4
5 **SECTION 5. Appropriation - adjustments to 2023 long bill.**
6 (1) To implement this act, appropriations made in the annual general
7 appropriation act for the 2023-24 state fiscal year to the department of
8 health care policy and financing are adjusted as follows:
9 (a) The general fund appropriation for use by the executive
10 director's office for personal services is increased by $18,326; and
11 (b) The general fund appropriation for use by the executive
12 director's office for operating expenses is increased by $337.
13 (2) For the 2023-24 state fiscal year, the general assembly
14 anticipates that federal funds received by the department of health care
15 policy and financing will decrease by $18,663 to implement this act,
16 which amount is subject to the "(I)" notation as defined in the annual
17 general appropriation act for the same fiscal year. The appropriation in
18 subsection (1) of this section is based on the assumption that the federal
19 funds received by the department will decrease as follows:
20 (a) $18,326 for personal services; and
21 (b) $337 for operating expenses.
22 (3) For the 2023-24 state fiscal year, $516,950 is appropriated to
23 the department of health care policy and financing for use by the
24 executive director's office. This appropriation is from the general fund.
25 To implement this act, the office may use this appropriation for general
26 professional services and special projects.
27 **SECTION 6. Safety clause.** The general assembly hereby finds,

1 determines, and declares that this act is necessary for the immediate
2 preservation of the public peace, health, or safety.