First Regular Session
Seventy-fourth General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 23-0468.03 Brita Darling x2241 **SENATE BILL 23-298**

SENATE SPONSORSHIP

Gardner and Roberts,

HOUSE SPONSORSHIP

McCormick and Bockenfeld,

Senate Committees
Health & Human Services

House Committees

A BILL FOR AN ACT

CONCERNING ALLOWING CERTAIN PUBLIC HOSPITALS TO IMPROVE ACCESS TO HEALTH CARE THROUGH COLLABORATION.

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 permits a hospital that has fewer than 50 beds and is a county public hospital, a hospital formed by a health service district, or a hospital affiliated with either such hospital (hospital) to enter into collaborative agreements to engage in activities that may be characterized as anticompetitive or result in displacement of competition, such as agreements to provide ancillary or specialty services, joint purchasing,

shared services, consulting, and collaboration efforts with payers.

The bill exempts collaborating hospitals from state antitrust laws and provides immunity from federal antitrust laws under the state action doctrine for approved collaborative activity.

Prior to entering into a collaborative agreement, the hospitals must submit the proposed collaborative agreement (proposal) to the department of health care policy and financing (department) and to the attorney general. If the department determines that the collaborative agreement will result in cost savings or other efficiencies that will improve or expand the delivery of health-care services in rural and frontier communities, the department must refer the proposal to the attorney general.

The attorney general must review each proposal that is referred by the department and determine, within a specified time, that the benefits are not outweighed by any anticompetitive harm that may result from the agreement. The department or the attorney general may request additional information concerning a proposal within 60 days after its original submission. If additional information is requested, the department and attorney general have an additional 45 days to review the proposal.

If the department and the attorney general make a favorable determination, the proposal is approved and the hospitals may enter into a collaborative agreement. If neither the department nor the attorney general respond within the time frames set forth in the bill, the collaborative proposal is deemed approved.

The department or the attorney general may review a collaborative agreement annually to ensure the outcomes related to the collaborative agreement are consistent with statute.

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

SECTION 1. In Colorado Revised Statutes, **add** 25-3-304.5 as follows:

25-3-304.5. Hospital collaborative agreements - reviews of proposed collaborative agreements - immunity - legislative declaration - definitions - rules. (1) THE GENERAL ASSEMBLY FINDS AND DECLARES THAT:

(a) (I) FRONTIER AND RURAL HOSPITALS CONTINUE TO STRUGGLE TO DELIVER HIGH-QUALITY, ACCESSIBLE, LOW-COST CARE DUE TO THE RISING COSTS OF MEDICATIONS, SUPPLIES, MEDICAL EQUIPMENT, AND

CONTRACT LABOR;

(II) FRONTIER AND RURAL HOSPITALS ARE LARGELY INDEPENDENT, GOVERNMENTAL FACILITIES THAT ARE GOVERNED BY LOCAL COMMUNITY BOARDS;

(III) FRONTIER AND RURAL HOSPITALS ARE GENERALLY SEPARATED BY LARGE DISTANCES AND ARE CHALLENGED BY THE NEED TO PROVIDE ESSENTIAL SERVICES TO LOCAL COMMUNITIES DUE TO THE SPARSE POPULATION IN RURAL AREAS;

(IV) FRONTIER AND RURAL HOSPITALS ARE INCREASINGLY CHALLENGED BY COMPLEX REQUIREMENTS IMPOSED BY GOVERNMENT AND PRIVATE PAYERS THAT DISPROPORTIONATELY NEGATIVELY IMPACT THESE PROVIDERS AND UNNECESSARILY DRIVE-UP ADMINISTRATIVE COSTS;

(V) DUE TO THE MARKET DYNAMICS OF HEALTH CARE AND THE FACT THAT MOST FRONTIER AND RURAL HOSPITALS ARE UNABLE TO PROVIDE TERTIARY AND QUATERNARY CARE TO THEIR COMMUNITIES, THERE IS LITTLE OPPORTUNITY FOR A GROUP OF FRONTIER AND RURAL HOSPITALS TO ESTABLISH MONOPOLY POWER IN THEIR RESPECTIVE MARKETS; AND

(VI) IT IS THE GENERAL ASSEMBLY'S INTENT TO PROVIDE PROTECTION TO FRONTIER AND RURAL HOSPITALS FROM UNNECESSARY ANTITRUST SCRUTINY THAT IMPEDES FRONTIER AND RURAL HOSPITALS FROM WORKING COLLABORATIVELY TO IMPROVE QUALITY, INCREASE ACCESS, AND REDUCE COSTS OF CARE TO THE COMMUNITIES THEY SERVE;

(b) (I) FORTY-SEVEN OF COLORADO'S SIXTY-FOUR COUNTIES INCLUDE RURAL AND FRONTIER COMMUNITIES YET CONTAIN ONLY TWELVE PERCENT OF COLORADO'S POPULATION;

(II) THIRTY-TWO COUNTIES ARE SERVED BY CRITICAL ACCESS HOSPITALS THAT HAVE TWENTY-FIVE OR FEWER BEDS AND ARE

GENERALLY LOCATED MORE THAN THIRTY-FIVE MILES FROM THE NEXT CLOSEST HOSPITAL; ELEVEN COUNTIES LACK ANY HOSPITAL;

(III) THE SCARCITY OF NEARBY HOSPITALS CAUSES MANY RESIDENTS TO STRUGGLE TO FIND QUALITY, AFFORDABLE HEALTH CARE NEAR THEIR HOMES;

(IV) FURTHER, MANY RESIDENTS IN COLORADO'S RURAL AND FRONTIER COMMUNITIES FOREGO PREVENTIVE AND BEHAVIORAL HEALTH CARE AND LACK COMPREHENSIVE OR SPECIALIZED CARE OR CHOICE IN HEALTH-CARE SERVICES, AND TWENTY-FOUR COUNTIES IN COLORADO ARE CONSIDERED MATERNAL CARE "DESERTS";

(V) WHERE HOSPITALS DO EXIST IN RURAL AND FRONTIER AREAS, THOSE HOSPITALS RECEIVE LOW REIMBURSEMENT RATES DUE TO A PREPONDERANCE OF GOVERNMENT PAYERS AND DECLINING LOCAL TAX DOLLARS, WHICH RESULTS IN A REDUCED AMOUNT OF MONEY AVAILABLE TO INVEST IN EXPANDING OR UPGRADING FACILITIES OR TO PURCHASE NECESSARY, NEW, OR INNOVATIVE MEDICAL SUPPLIES, EQUIPMENT, OR TECHNOLOGY;

(VI) AS A RESULT, MANY HOSPITALS IN RURAL AND FRONTIER COMMUNITIES HAVE DIFFICULTY RECRUITING AND RETAINING QUALIFIED HEALTH-CARE PROFESSIONALS AND MAKING AVAILABLE NEEDED SERVICES; AND

(VII) COUNTY PUBLIC HOSPITALS, HEALTH SERVICE DISTRICTS, AND HOSPITAL AFFILIATES PERFORM ESSENTIAL PUBLIC FUNCTIONS ON BEHALF OF THE STATE;

(c) AS PART OF THE GOVERNMENT'S INTEREST IN PROVIDING NEEDED HEALTH-CARE SERVICES IN COLORADO'S RURAL AND FRONTIER COMMUNITIES, IT IS IMPORTANT FOR THE GOVERNMENT TO SUPPORT RURAL HEALTH-CARE LEADERS' EFFORTS TO FIND COLLABORATIVE, INNOVATIVE

SOLUTIONS TO THE MANY PROBLEMS THEY CONFRONT, INCLUDING COLLABORATIVE OR COORDINATED ACTIVITIES THAT OFFER THE OPPORTUNITY TO EXPAND HEALTH-CARE OPTIONS THROUGH JOINT PURCHASING AND STAFFING, SHARED SERVICES, AND JOINT ACQUISITION OF NEW AND EXPENSIVE DIAGNOSTIC AND TREATMENT SOLUTIONS;

(d) IT IS THE GENERAL ASSEMBLY'S INTENT TO EXEMPT FROM STATE ANTITRUST LAWS, AND TO PROVIDE STATE ACTION IMMUNITY FROM FEDERAL ANTITRUST LAWS FOR CERTAIN ACTIVITIES THAT MIGHT BE CHARACTERIZED AS ANTICOMPETITIVE OR THAT MIGHT RESULT IN THE DISPLACEMENT OF COMPETITION IN THE PROVISION OF HOSPITAL, PHYSICIAN, OR OTHER HEALTH-CARE-RELATED SERVICES OR ADMINISTRATIVE OR GENERAL BUSINESS SERVICES;

(e) IN ORDER TO PROMOTE IMPROVED QUALITY OF, INCREASE ACCESS TO, AND REDUCE COSTS OF HEALTH-CARE SERVICES IN RURAL AND FRONTIER COMMUNITIES THROUGH COLLABORATIVE AGREEMENTS AUTHORIZED BY THIS SECTION, THE GENERAL ASSEMBLY FURTHER INTENDS TO PROVIDE A SYSTEM OF REVIEW OF RELEVANT COLLABORATIVE AGREEMENTS BY THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING AND THE ATTORNEY GENERAL TO ENSURE THAT ANY POTENTIAL BENEFITS OF SUCH COLLABORATIVE AGREEMENTS ARE NOT OUTWEIGHED BY THE HARM TO COMPETITION IN RURAL AND FRONTIER COMMUNITIES; AND

(f) AS AN EXPRESSION OF THE PUBLIC POLICY OF THE STATE WITH RESPECT TO THE DISPLACEMENT OF COMPETITION IN THE FIELD OF HEALTH CARE, EACH HOSPITAL, WHEN EXERCISING ITS POWERS PURSUANT TO THIS SECTION, IS ACTING AS A POLITICAL SUBDIVISION OF THE STATE, INCLUDING WHEN PARTICIPATING IN A REVIEW OF A PROPOSED COLLABORATIVE AGREEMENT, AND, AS SUCH, IS NOT SUBJECT TO ACTIVE

SUPERVISION BY THE STATE IN ORDER TO ENJOY IMMUNITY FROM THE APPLICATION OF STATE AND FEDERAL ANTITRUST LAWS.

(2) AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(a) "COLLABORATIVE AGREEMENT" MEANS AN AGREEMENT OR SIMILAR ARRANGEMENT BETWEEN TWO OR MORE HOSPITALS OR HOSPITAL AFFILIATES THAT COMPLIES WITH THE REQUIREMENTS SET FORTH IN THIS SECTION.

(b) "COUNTY PUBLIC HOSPITAL" MEANS A PUBLIC HOSPITAL ESTABLISHED PURSUANT TO SECTION 25-3-301.

(c) "HEALTH SERVICE DISTRICT" HAS THE SAME MEANING AS SET FORTH IN SECTION 32-1-103 (9).

(d) "HOSPITAL" MEANS A FACILITY WITH FEWER THAN FIFTY BEDS THAT IS:

(I) A COUNTY PUBLIC HOSPITAL;

(II) A HOSPITAL ESTABLISHED, MAINTAINED, OR OPERATED DIRECTLY OR INDIRECTLY BY A HEALTH SERVICE DISTRICT; OR

(III) A HOSPITAL AFFILIATE.

(e) "HOSPITAL AFFILIATE" MEANS AN AFFILIATE OF A COUNTY PUBLIC HOSPITAL OR HEALTH SERVICE DISTRICT THAT IS UNDER THE SOLE CONTROL OF THE COUNTY PUBLIC HOSPITAL OR HEALTH SERVICE DISTRICT.

(3) EXCEPT AS PROVIDED IN SUBSECTION (4) OF THIS SECTION, AND SUBJECT TO THE REQUIREMENTS IN SUBSECTIONS (5) AND (6) OF THIS SECTION, A HOSPITAL IS AUTHORIZED TO ENTER INTO COLLABORATIVE AGREEMENTS WITH ONE OR MORE HOSPITALS OR HOSPITAL AFFILIATES TO ENGAGE IN THE FOLLOWING ACTIVITIES:

(a) ANCILLARY CLINICAL SERVICES, ACQUISITION OF EQUIPMENT, CLINIC MANAGEMENT, OR HEALTH-CARE PROVIDER RECRUITMENT;

(b) JOINT PURCHASING OR LEASING ARRANGEMENTS, INCLUDING THE JOINT PURCHASING OR LEASING OF:

(I) MEDICAL AND GENERAL SUPPLIES;

(II) MEDICAL AND GENERAL EQUIPMENT;

(III) PHARMACEUTICALS; OR

(IV) TEMPORARY STAFFING THROUGH A STAFFING AGENCY;

(c) CONSULTING SERVICES WITH A FOCUS ON PUBLIC HEALTH IN RURAL OR FRONTIER COMMUNITIES AND NON-HOSPITAL-SPECIFIC INNOVATIONS IN HEALTH-CARE DELIVERY IN THOSE COMMUNITIES;

(d) PURCHASING JOINT PROFESSIONAL, GENERAL LIABILITY, OR PROPERTY INSURANCE;

(e) SHARING BACK-OFFICE SERVICES, SUCH AS SHARING A BUSINESS OFFICE, ACCOUNTING AND FINANCE SERVICES, HUMAN RESOURCES, AND RISK MANAGEMENT AND COMPLIANCE SERVICES, BUT NOT INCLUDING SHARING SERVICE CHARGING EXPENSES OR RATES AMONG HOSPITALS;

(f) SHARING DATA SERVICES, INCLUDING SHARED SERVICES FOR ELECTRONIC HEALTH RECORDS AND DATA EXTRACTION AND ANALYSIS SERVICES, CHARGE MANAGEMENT, AND POPULATION HEALTH ANALYSIS; AND

(g) NEGOTIATING WITH HEALTH INSURANCE OR GOVERNMENT PAYERS, WHICH NEGOTIATIONS ARE LIMITED TO:

(I) SHARED CARE PROTOCOLS INTENDED TO IMPROVE PATIENT MANAGEMENT AND OUTCOMES, INCLUDING IMPLEMENTATION OF EVIDENCE-BASED PROTOCOLS, CLINICAL PATHWAYS, AND RECOGNIZED BEST PRACTICES IN THE CARE AND TREATMENT OF PATIENTS, INCLUDING CLINICAL THERAPIES, NUTRITION, EXERCISE, DIAGNOSTIC TESTING, AND MEDICATION MANAGEMENT;

(II) COLLABORATIVE EFFORTS WITH PAYERS TO PROMOTE

APPROPRIATE AND ESSENTIAL SERVICES TO BE PROVIDED IN THE LOCAL COMMUNITY;

(III) MANAGEMENT OF PRIOR AUTHORIZATION REQUESTS; AND

(IV) ANALYSIS OF AGGREGATE DATA TO COMPARE COSTS OF PROCEDURES AND TO ANALYZE PATIENT OUTCOMES.

(4) NOTWITHSTANDING ANY COLLABORATIVE AGREEMENTS AUTHORIZED UNDER SUBSECTION (3) OF THIS SECTION, THE IMMUNITY AND PROTECTIONS GRANTED TO HOSPITALS AND HOSPITAL AFFILIATES ENTERING INTO SUCH COLLABORATIVE AGREEMENTS PURSUANT TO THIS SECTION DOES NOT EXTEND TO COLLABORATIVE AGREEMENTS WITH ANOTHER HOSPITAL OR HOSPITAL AFFILIATE THAT HAVE THE EFFECT OF:

(a) SETTING REIMBURSEMENT RATES OR OTHER COMPENSATION FROM ANY COMMERCIAL SELF-INSURED OR COMMERCIAL HEALTH INSURANCE OR GOVERNMENT PAYER;

(b) DIVIDING OR ALLOCATING AMONG HOSPITALS OR HOSPITAL AFFILIATES SPECIFIC MARKETS FOR THE DELIVERY OF ANY GENERAL ACUTE CARE OR SPECIALTY LINES OF HEALTH-CARE SERVICES; OR

(c) NEGOTIATING OR AGREEING TO COMPENSATION UNDER HEALTH-CARE STAFFING ARRANGEMENTS FOR HOSPITAL EMPLOYEES THAT RESULTS IN A REDUCTION OF WAGES OF HOSPITAL-EMPLOYED STAFF.

(5) PRIOR TO ENGAGING IN ANY JOINT ACTIVITY DESCRIBED BY A PROPOSED COLLABORATIVE AGREEMENT EXECUTED PURSUANT TO SUBSECTION (3) OF THIS SECTION, THE HOSPITALS OR HOSPITAL AFFILIATES SHALL JOINTLY SUBMIT THE PROPOSED COLLABORATIVE AGREEMENT TO THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING, PURSUANT TO RULES WHICH MAY BE PROMULGATED FOR THE SUBMISSION OF PROPOSALS. THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING MAY REQUEST ADDITIONAL INFORMATION NECESSARY FOR THE DEPARTMENT OF HEALTH

CARE POLICY AND FINANCING TO REVIEW THE PROPOSAL.

(6) IF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING CONCLUDES THAT A PROPOSED COLLABORATIVE ACTIVITY MAY RESULT IN COST SAVINGS OR OTHER EFFICIENCIES THAT MAY IMPROVE OR EXPAND THE DELIVERY OF HEALTH-CARE SERVICES IN RURAL AND FRONTIER COMMUNITIES IN COLORADO, THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING SHALL REFER THE PROPOSAL TO THE ATTORNEY GENERAL TO DETERMINE, PURSUANT TO RULES WHICH MAY BE PROMULGATED FOR SUCH PURPOSE, THAT THE BENEFITS OF THE COLLABORATIVE ACTIVITY ARE NOT OUTWEIGHED BY ANY ANTICOMPETITIVE HARM THAT MAY ARISE FROM THE COLLABORATIVE ACTIVITY.

(7) WITHIN SIXTY DAYS AFTER RECEIVING A PROPOSED COLLABORATIVE AGREEMENT, THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING AND THE ATTORNEY GENERAL SHALL REVIEW THE PROPOSED COLLABORATIVE AGREEMENT AND EITHER APPROVE OR DENY THE PROPOSED COLLABORATIVE AGREEMENT OR REQUEST ADDITIONAL INFORMATION RELATED TO THE PROPOSAL. IF A REQUEST FOR ADDITIONAL INFORMATION IS MADE, THE ATTORNEY GENERAL HAS AN ADDITIONAL FORTY-FIVE DAYS TO COMPLETE THE REVIEW.

(8) (a) IF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING AND THE ATTORNEY GENERAL CONCLUDE THAT A PROPOSED COLLABORATIVE AGREEMENT MAY RESULT IN IMPROVED QUALITY, INCREASED ACCESS OR COST SAVINGS, OR OTHER EFFICIENCIES THAT MAY IMPROVE OR EXPAND THE DELIVERY OF HEALTH-CARE SERVICES IN RURAL AND FRONTIER COMMUNITIES IN COLORADO, THE PROPOSAL IS APPROVED. IF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING OR THE ATTORNEY GENERAL DOES NOT RESPOND WITHIN THE TIME FRAMES SPECIFIED IN THIS SECTION, THE COLLABORATIVE ACTIVITY IS DEEMED

APPROVED.

(b) THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING OR THE ATTORNEY GENERAL MAY REVIEW A COLLABORATIVE AGREEMENT ANNUALLY TO ENSURE THE OUTCOMES RELATED TO THE COLLABORATIVE AGREEMENT ARE CONSISTENT WITH THIS SECTION. THE SCOPE OF THE REVIEW SHALL BE DETERMINED BY RULES PROMULGATED BY THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING AND THE ATTORNEY GENERAL.

SECTION 2. In Colorado Revised Statutes, 32-1-1003, **add** (1)(c.5) as follows:

32-1-1003. Health service districts - additional powers. (1) In addition to the powers specified in section 32-1-1001, the board of any health service district has any or all of the following powers for and on behalf of such district:

(c.5) TO ENTER INTO A COLLABORATIVE AGREEMENT WITH ANOTHER HEALTH SERVICE DISTRICT, COUNTY PUBLIC HOSPITAL, OR HOSPITAL AFFILIATE IN ACCORDANCE WITH SECTION 25-3-304.5.

SECTION 3. Act subject to petition - effective date. This act takes effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly; except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part will not take effect unless approved by the people at the general election to be held in November 2024 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.