CHAPTER 277

HEALTH AND ENVIRONMENT

HOUSE BILL 23-1215

BY REPRESENTATIVE(S) Sirota and Boesenecker, Bacon, Brown, Epps, Froelich, Gonzales-Gutierrez, Herod, Jodeh, Kipp, Lindsay, Mabrey, Marshall, Ortiz, Sharbini, Valdez, Weissman, Willford, Amabile, English, McCormick, Ricks, Velasco; also SENATOR(S) Mullica and Cutter, Buckner, Exum, Fields, Jaquez Lewis, Priola.

AN ACT

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

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

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

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

(a) "AFFILIATED WITH" MEANS:

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

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

(b) "CAMPUS" MEANS:

(I) A HOSPITAL'S MAIN BUILDINGS;

(II) THE PHYSICAL AREA IMMEDIATELY ADJACENT TO A HOSPITAL'S MAIN BUILDINGS AND STRUCTURES OWNED BY THE HOSPITAL THAT ARE NOT STRICTLY CONTIGUOUS TO THE MAIN BUILDINGS BUT ARE LOCATED WITHIN TWO HUNDRED FIFTY YARDS OF THE MAIN BUILDINGS; OR

Capital letters or bold & italic numbers indicate new material added to existing law; dashes through words or numbers indicate deletions from existing law and such material is not part of the act.

(III) ANY OTHER AREA THAT THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES IN THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES HAS DETERMINED, ON AN INDIVIDUAL-CASE BASIS, TO BE PART OF A HOSPITAL'S CAMPUS.

(c) "CRITICAL ACCESS HOSPITAL" MEANS A HOSPITAL THAT IS FEDERALLY CERTIFIED OR UNDERGOING FEDERAL CERTIFICATION AS A CRITICAL ACCESS HOSPITAL PURSUANT TO 42 CFR 485, SUBPART F.

(d) "FACILITY FEE" MEANS ANY FEE A HOSPITAL OR HEALTH SYSTEM CHARGES OR BILLS FOR OUTPATIENT HOSPITAL SERVICES THAT IS:

(I) INTENDED TO COMPENSATE THE HOSPITAL OR HEALTH SYSTEM FOR ITS OPERATIONAL EXPENSES; AND

(II) SEPARATE AND DISTINCT FROM A PROFESSIONAL FEE CHARGED OR BILLED BY A HEALTH-CARE PROVIDER FOR PROFESSIONAL MEDICAL SERVICES.

(e) "FREESTANDING EMERGENCY DEPARTMENT" MEANS A HEALTH FACILITY AS DEFINED IN AND REQUIRED TO BE LICENSED UNDER SECTION 25-1.5-114.

(f) "HEALTH-CARE PROVIDER" MEANS ANY PERSON, INCLUDING A HEALTH FACILITY, THAT IS LICENSED OR OTHERWISE AUTHORIZED IN THIS STATE TO FURNISH A HEALTH-CARE SERVICE.

(g) "HEALTH-CARE SERVICE" HAS THE MEANING SET FORTH IN SECTION 10-16-102 (33).

(h) "HEALTH FACILITY" MEANS A FACILITY LICENSED OR CERTIFIED PURSUANT TO SECTION 25-1.5-103 OR ESTABLISHED PURSUANT TO PART 5 OF ARTICLE 21 OF TITLE 23 OR ARTICLE 29 OF TITLE 25.

(i) "HEALTH SYSTEM" HAS THE MEANING SET FORTH IN SECTION 10-16-1303 (9).

(j) "HOSPITAL" MEANS A HOSPITAL CURRENTLY LICENSED OR CERTIFIED BY THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT PURSUANT TO THE DEPARTMENT'S AUTHORITY UNDER SECTION 25-1.5-103 (1)(a) OR ESTABLISHED PURSUANT TO PART 5 OF ARTICLE 21 OF TITLE 23 OR ARTICLE 29 OF TITLE 25.

(k) "MEDICARE" MEANS THE "HEALTH INSURANCE FOR THE AGED ACT", TITLE XVIII OF THE FEDERAL "SOCIAL SECURITY ACT", AS AMENDED BY THE SOCIAL SECURITY AMENDMENTS OF 1965, AND AS LATER AMENDED.

(l) "OFF-CAMPUS LOCATION" HAS THE MEANING SET FORTH IN SECTION 25-3-118.

(m) "OWNED BY" MEANS OWNED BY A HOSPITAL OR HEALTH SYSTEM WHEN BILLED UNDER THE HOSPITAL'S TAX IDENTIFICATION NUMBER.

(n) "PAYER TYPE" MEANS COMMERCIAL INSURERS; MEDICARE; THE MEDICAL ASSISTANCE PROGRAM ESTABLISHED PURSUANT TO ARTICLES 4 TO 6 OF TITLE 25.5;

INDIVIDUALS WHO SELF-PAY; A FINANCIAL ASSISTANCE PLAN; OR THE "COLORADO INDIGENT CARE PROGRAM", ESTABLISHED IN PART 1 OF ARTICLE 3 OF TITLE 25.5.

(o) "SOLE COMMUNITY HOSPITAL" HAS THE MEANING SET FORTH 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 AND AGAIN AT THE TIME THE HEALTH-CARE SERVICES ARE RENDERED; AND

(B) POST A SIGN, IN ENGLISH AND SPANISH AND THAT IS PLAINLY VISIBLE AND LOCATED IN THE AREA WITHIN THE HEALTH FACILITY WHERE AN INDIVIDUAL SEEKING CARE REGISTERS OR CHECKS IN, THAT STATES THAT THE PATIENT MAY BE CHARGED A FACILITY FEE IN ADDITION TO THE COST OF THE HEALTH-CARE SERVICE. THE SIGN MUST ALSO INCLUDE A LOCATION WITHIN THE HEALTH FACILITY WHERE A PATIENT MAY INQUIRE ABOUT FACILITY FEES AND AN ONLINE LOCATION WHERE INFORMATION ABOUT FACILITY FEES MAY BE FOUND.

(II) PROVIDE TO A PATIENT A STANDARDIZED BILL THAT:

(A) INCLUDES ITEMIZED CHARGES FOR EACH HEALTH-CARE SERVICE;

(B) SPECIFICALLY IDENTIFIES ANY FACILITY FEE;

(C) IDENTIFIES SPECIFIC CHARGES THAT HAVE BEEN BILLED TO INSURANCE OR OTHER PAYER TYPES FOR HEALTH-CARE SERVICES; AND

(D) INCLUDES CONTACT INFORMATION FOR FILING AN APPEAL WITH THE HEALTH-CARE PROVIDER TO CONTEST CHARGES.

(b) THE HEALTH-CARE PROVIDER SHALL PROVIDE THE REQUIRED NOTICE AND STANDARDIZED BILL IN A CLEAR MANNER AND, TO THE EXTENT PRACTICABLE, IN THE PATIENT'S PREFERRED LANGUAGE.

(c) (I) A HEALTH FACILITY THAT IS NEWLY AFFILIATED WITH OR OWNED BY A HOSPITAL OR HEALTH SYSTEM ON OR AFTER JULY 1, 2024, SHALL PROVIDE WRITTEN NOTICE TO EACH PATIENT RECEIVING SERVICES WITHIN THE TWELVE-MONTH PERIOD IMMEDIATELY PRECEDING THE AFFILIATION OR CHANGE OF OWNERSHIP THAT THE HEALTH FACILITY IS PART OF A HOSPITAL OR HEALTH SYSTEM. THE NOTICE MUST INCLUDE:

(A) THE NAME, BUSINESS ADDRESS, AND PHONE NUMBER OF THE HOSPITAL OR HEALTH SYSTEM THAT IS THE PURCHASER OF THE HEALTH FACILITY OR WITH WHOM THE HEALTH FACILITY IS AFFILIATED;

(B) A STATEMENT THAT THE HEALTH FACILITY BILLS, OR IS LIKELY TO BILL, PATIENTS A FACILITY FEE THAT MAY BE IN ADDITION TO AND SEPARATE FROM ANY PROFESSIONAL FEE BILLED BY A HEALTH-CARE PROVIDER AT THE HEALTH FACILITY; AND

(C) A STATEMENT THAT, PRIOR TO SEEKING SERVICES AT THE HEALTH FACILITY, A PATIENT COVERED BY A HEALTH INSURANCE POLICY OR HEALTH BENEFIT PLAN SHOULD CONTACT THE PATIENT'S HEALTH INSURER FOR ADDITIONAL INFORMATION REGARDING THE HEALTH FACILITY'S FACILITY FEES, INCLUDING THE PATIENT'S POTENTIAL FINANCIAL LIABILITY, IF ANY, FOR THE FACILITY FEES.

(II) A HOSPITAL, HEALTH SYSTEM, OR HEALTH FACILITY SHALL NOT COLLECT A FACILITY FEE FOR HEALTH-CARE SERVICES PROVIDED BY A HEALTH-CARE PROVIDER AFFILIATED WITH OR OWNED BY A HOSPITAL OR HEALTH SYSTEM THAT IS SUBJECT TO ANY PROVISIONS OF THIS SECTION FROM THE DATE OF THE TRANSACTION UNTIL AT LEAST THIRTY DAYS AFTER THE WRITTEN NOTICE REQUIRED PURSUANT TO SUBSECTION (3)(c)(I) OF THIS SECTION IS MAILED TO THE PATIENT.

(4) SUBSECTION (2) OF THIS SECTION DOES NOT APPLY TO A CRITICAL ACCESS HOSPITAL, A SOLE COMMUNITY HOSPITAL IN A RURAL OR FRONTIER AREA, OR A COMMUNITY CLINIC AFFILIATED WITH A SOLE COMMUNITY HOSPITAL IN A RURAL OR FRONTIER AREA.

(5) SUBSECTION (2) OF THIS SECTION DOES NOT APPLY TO A HOSPITAL ESTABLISHED PURSUANT TO ARTICLE 29 OF TITLE 25.

SECTION 2. In Colorado Revised Statutes, **add** 10-16-164 as follows:

10-16-164. Hospital facility fee report - data collection. THE COMMISSIONER IS AUTHORIZED TO COLLECT FROM A CARRIER OFFERING A HEALTH BENEFIT PLAN

INFORMATION SPECIFIED IN SECTION 25.5-4-216, IF AVAILABLE, FOR PURPOSES OF FACILITATING THE DEVELOPMENT OF THE REPORT RELATING TO FACILITY FEES.

SECTION 3. In Colorado Revised Statutes, 6-1-105, **add** (1)(aaaa) as follows:

6-1-105. Unfair or deceptive trade practices. (1) A person engages in a deceptive trade practice when, in the course of the person's business, vocation, or occupation, the person:

(aaaa) CHARGES, BILLS, OR COLLECTS A FACILITY FEE OR FAILS TO COMPLY WITH OTHER PROVISIONS RELATING TO FACILITY FEES IN VIOLATION OF SECTION 6-20-102 (2) OR (3).

SECTION 4. In Colorado Revised Statutes, **add** 25.5-4-216 as follows:

25.5-4-216. Report on impact of hospital facility fees in Colorado - definitions - steering committee - repeal. (1) AS USED IN THIS SECTION:

(a) "AFFILIATED WITH" HAS THE MEANING SET FORTH IN SECTION 6-20-102 (1)(a).

(b) "CAMPUS" HAS THE SAME MEANING SET FORTH IN SECTION 6-20-102 (1)(b).

(c) "CPT CODE" HAS THE MEANING SET FORTH IN SECTION 25.5-1-204.7 (1)(d).

(d) "FACILITY FEE" HAS THE MEANING SET FORTH IN SECTION 6-20-102 (1)(d).

(e) "HEALTH-CARE PROVIDER" HAS THE MEANING SET FORTH IN SECTION 6-20-102 (1)(f).

(f) "HEALTH SYSTEM" HAS THE MEANING SET FORTH IN SECTION 10-16-1303 (9).

(g) "HOSPITAL" HAS THE MEANING SET FORTH IN SECTION 6-20-102 (1)(j).

(h) "OWNED BY" HAS THE MEANING SET FORTH IN SECTION 6-20-102 (1)(m).

(i) "PAYER TYPE" HAS THE MEANING SET FORTH IN SECTION 6-20-102 (1)(n).

(j) "STEERING COMMITTEE" MEANS THE STEERING COMMITTEE CREATED IN SUBSECTION (2) OF THIS SECTION.

(2) THERE IS CREATED IN THE STATE DEPARTMENT A STEERING COMMITTEE TO RESEARCH AND REPORT ON THE IMPACT OF OUTPATIENT FACILITY FEES. THE STEERING COMMITTEE CONSISTS OF THE FOLLOWING SEVEN MEMBERS APPOINTED BY THE GOVERNOR WITH RELEVANT EXPERTISE IN HEALTH-CARE BILLING AND PAYMENT POLICY:

(a) TWO MEMBERS REPRESENTING HEALTH-CARE CONSUMERS, WITH AT LEAST ONE OF THE MEMBERS REPRESENTING A HEALTH-CARE CONSUMER ADVOCACY ORGANIZATION;

(b) ONE MEMBER REPRESENTING A HEALTH-CARE PAYER OR PAYERS;

(c) ONE MEMBER REPRESENTING HEALTH-CARE PROVIDERS NOT AFFILIATED WITH OR OWNED BY A HOSPITAL OR HEALTH SYSTEM OR WHO HAS INDEPENDENT PHYSICIAN BILLING EXPERTISE;

(d) ONE MEMBER REPRESENTING A STATEWIDE ASSOCIATION OF HOSPITALS;

(e) ONE MEMBER REPRESENTING A RURAL, CRITICAL ACCESS, OR INDEPENDENT HOSPITAL; AND

(f) THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING, OR THE EXECUTIVE DIRECTOR'S DESIGNEE.

(3) (a) THE STEERING COMMITTEE SHALL FACILITATE THE DEVELOPMENT OF A REPORT DETAILING THE IMPACT OF OUTPATIENT FACILITY FEES ON THE COLORADO HEALTH-CARE SYSTEM, INCLUDING THE IMPACT ON CONSUMERS, EMPLOYERS, HEALTH-CARE PROVIDERS, AND HOSPITALS. IN DEVELOPING VARIOUS ASPECTS OF THE REPORT REQUIRED IN THIS SECTION, THE STEERING COMMITTEE SHALL WORK WITH INDEPENDENT THIRD PARTIES TO CONDUCT RELATED RESEARCH AND ANALYSIS NECESSARY TO IDENTIFY AND EVALUATE THE IMPACT OF OUTPATIENT FACILITY FEES.

(b) THE STEERING COMMITTEE SHALL PREPARE A PRELIMINARY VERSION OF THE REPORT ON OR BEFORE AUGUST 1, 2024, UNLESS MORE TIME IS REQUIRED, AND A FINAL REPORT ON OR BEFORE OCTOBER 1, 2024, THAT MUST BE SUBMITTED TO THE HOUSE OF REPRESENTATIVES HEALTH AND INSURANCE COMMITTEE AND THE SENATE HEALTH AND HUMAN SERVICES COMMITTEE, OR THEIR SUCCESSOR COMMITTEES.

(4) (a) FOR PURPOSES OF DEVELOPING THE REPORT, THE STEERING COMMITTEE, WITH ADMINISTRATIVE SUPPORT FROM THE STATE DEPARTMENT, MAY:

(I) SELECT THIRD-PARTY CONTRACTORS TO ASSIST IN RESEARCHING AND CREATING THE REPORT, WITH AN APPROPRIATION MADE TO THE STATE DEPARTMENT FOR SUCH PURPOSE;

(II) DEVELOP THE FORMAT, SCOPE, AND TEMPLATES FOR REQUESTS FOR INFORMATION;

(III) REVIEW DRAFTS, PROVIDE FEEDBACK, AND FINALIZE THE REPORT;

(IV) ANSWER TECHNICAL QUESTIONS FROM THIRD-PARTY CONTRACTORS; AND

(V) CONSULT WITH EXTERNAL STAKEHOLDERS.

(b) THE STEERING COMMITTEE, STATE DEPARTMENT, AND ANY THIRD-PARTY CONTRACTORS ENGAGED IN THE DEVELOPMENT OF THE REPORT ARE ENCOURAGED TO USE BOTH PRIMARY AND SECONDARY SOURCES AND RESEARCH, WHERE POSSIBLE, AND, TO THE EXTENT FEASIBLE, ENSURE THE REPORT IS WELL-INFORMED BY THE PERSPECTIVES OF DIVERSE STAKEHOLDERS. THE STEERING COMMITTEE SHALL WORK ONLY WITH THIRD-PARTY CONTRACTORS THAT ARE ALREADY APPROVED AS ONE OF THE STATE DEPARTMENT'S PROJECT-BASED CONTRACTS.

(c) TO THE EXTENT PRACTICABLE, EVALUATION AND ANALYSIS PERFORMED FOR

THE REPORT MUST ATTEMPT TO LEVERAGE COLORADO-SPECIFIC DATA SOURCES AND PUBLICLY AVAILABLE NATIONAL DATA AND RESEARCH.

(5) THE REPORT MUST IDENTIFY AND EVALUATE:

(a) PAYER REIMBURSEMENT AND PAYMENT POLICIES FOR OUTPATIENT FACILITY FEES ACROSS PAYER TYPES, INCLUDING INSIGHTS, WHERE AVAILABLE, INTO CHANGES OVER TIME, AS WELL AS PROVIDER BILLING GUIDELINES AND PRACTICES FOR OUTPATIENT FACILITY FEES ACROSS PROVIDER TYPES, INCLUDING INSIGHTS, WHERE AVAILABLE, INTO CHANGES MADE OVER TIME;

(b) PAYMENTS FOR OUTPATIENT FACILITY FEES, INCLUDING INSIGHTS INTO THE ASSOCIATED CARE ACROSS PAYER TYPES;

(c) COVERAGE AND COST-SHARING PROVISIONS FOR OUTPATIENT CARE SERVICES ASSOCIATED WITH FACILITY FEES ACROSS PAYERS AND PAYER TYPES;

(d) DENIED FACILITY FEE CLAIMS BY PAYER TYPE AND PROVIDER TYPE;

(e) THE IMPACT OF FACILITY FEES AND PAYER COVERAGE POLICIES ON CONSUMERS, SMALL AND LARGE EMPLOYERS, AND THE MEDICAL ASSISTANCE PROGRAM;

(f) THE IMPACT OF FACILITY FEES AND PAYER COVERAGE POLICIES ON THE CHARGES FOR HEALTH-CARE SERVICES RENDERED BY INDEPENDENT HEALTH-CARE PROVIDERS, INCLUDING A COMPARISON OF PROFESSIONAL FEE CHARGES AND FACILITY FEE CHARGES; AND

(g) THE CHARGES FOR HEALTH-CARE SERVICES RENDERED BY HEALTH-CARE PROVIDERS AFFILIATED WITH OR OWNED BY A HOSPITAL OR HEALTH SYSTEM, AND INCLUDING A COMPARISON OF PROFESSIONAL FEE AND FACILITY FEE CHARGES.

(6) THE REPORT MUST INCLUDE AN ANALYSIS OF:

(a) DATA FROM THE COLORADO ALL-PAYER HEALTH CLAIMS DATABASE AS REPORTED UNDER DSG14, INCLUDING, AT A MINIMUM:

(I) THE NUMBER OF PATIENT VISITS FOR WHICH FACILITY FEES WERE CHARGED, INCLUDING, TO THE EXTENT POSSIBLE, A BREAKDOWN OF WHICH VISITS WERE IN-NETWORK AND WHICH WERE OUT-OF-NETWORK;

(II) TO THE EXTENT POSSIBLE, THE NUMBER OF PATIENT VISITS FOR WHICH THE FACILITY FEES WERE CHARGED OUT-OF-NETWORK AND THE PROFESSIONAL FEES WERE CHARGED IN-NETWORK FOR THE SAME OUTPATIENT SERVICE;

(III) THE TOTAL ALLOWED FACILITY FEE AMOUNTS BILLED AND DENIED;

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

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

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

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

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

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

(II) THE TOTAL REVENUE COLLECTED IN FACILITY FEES;

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

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

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

(A) HISTORIC AND CURRENT BUSINESS NAMES AND ADDRESSES;

(B) HISTORIC AND CURRENT TAX IDENTIFICATION NUMBERS AND NATIONAL PROVIDER IDENTIFIERS;

(C) HEALTH-CARE PROVIDER ACQUISITION OR AFFILIATION DATE;

(D) FACILITY FEE BILLING POLICIES, INCLUDING WHETHER ANY CHANGES WERE MADE TO SUCH POLICIES BEFORE OR AFTER THE ACQUISITION OR AFFILIATION DATE; AND

(E) THE TOP TEN CPT CODES, REVENUE CODES, OR COMBINATION THEREOF, AT THE STATE DEPARTMENT'S DISCRETION, FOR WHICH A FACILITY FEE IS BILLED AND THE PROFESSIONAL FEE AMOUNT FOR THE SAME SERVICE;

(c) DATA, IF AVAILABLE, FROM THE STATE DEPARTMENT, THE DIVISION OF INSURANCE, AND COMMERCIAL PAYERS, INCLUDING:

(I) THE PAYMENT POLICY EACH PAYER USES FOR PAYMENT OF FACILITY FEES FOR NETWORK PRODUCTS, INCLUDING ANY CHANGES THAT WERE MADE TO SUCH POLICIES WITHIN THE LAST FIVE YEARS;

(II) A LIST OF COMMON PROCEDURES ASSOCIATED WITH FACILITY FEES;

(III) EACH PAYER'S NETWORK PRODUCT NAMES;

(IV) PAID AGGREGATE FACILITY FEE BILLINGS FROM OUTPATIENT PROVIDERS AND THE ASSOCIATED NUMBER OF FACILITY FEE CLAIMS, BROKEN DOWN BY HOSPITAL OR HEALTH SYSTEM; AND

(V) A DESCRIPTION OF THE ESTIMATED IMPACT OF FACILITY FEES ON PREMIUM RATES, OUT-OF-NETWORK CLAIMS, MEMBER COST SHARING, AND EMPLOYER COSTS;

(d) DATA FROM INDEPENDENT HEALTH-CARE PROVIDERS THAT ARE NOT AFFILIATED WITH OR OWNED BY A HOSPITAL OR HEALTH SYSTEM, INCLUDING:

(I) HISTORIC AND CURRENT BUSINESS NAMES AND ADDRESSES;

(II) HISTORIC AND CURRENT TAX IDENTIFICATION NUMBERS AND NATIONAL PROVIDER IDENTIFIERS;

(III) FACILITY FEE BILLING POLICIES, INCLUDING WHETHER ANY CHANGES WERE MADE TO SUCH POLICIES IN THE PAST FIVE YEARS; AND

(IV) WHERE APPLICABLE, THE TOP TEN CPT CODES, REVENUE CODES, OR COMBINATION THEREOF, AT THE STEERING COMMITTEE'S DISCRETION, FOR WHICH A FACILITY FEE IS BILLED AND THE PROFESSIONAL FEE AMOUNT FOR THE SAME SERVICE;

(e) THE IMPACT OF FACILITY FEES AND PAYER COVERAGE POLICIES ON THE COLORADO HEALTHCARE AFFORDABILITY AND SUSTAINABILITY ENTERPRISE, CREATED IN SECTION 25.5-4-402.4, THE MEDICAID EXPANSION, UNCOMPENSATED CARE, AND UNDERCOMPENSATED CARE;

(f) THE IMPACT OF FACILITY FEES ON ACCESS TO CARE, INCLUDING SPECIALTY CARE, PRIMARY CARE, AND BEHAVIORAL HEALTH CARE; INTEGRATED CARE SYSTEMS; HEALTH EQUITY; AND THE HEALTH-CARE WORKFORCE; AND

(g) A DESCRIPTION OF THE WAY IN WHICH HEALTH-CARE PROVIDERS MAY BE PAID OR REIMBURSED BY PAYERS FOR OUTPATIENT HEALTH-CARE SERVICES, WITH OR WITHOUT FACILITY FEES, THAT EXPLORES ANY LEGAL AND HISTORICAL REASONS FOR SPLIT BILLING BETWEEN PROFESSIONAL AND FACILITY FEES AT:

(I) ON-CAMPUS LOCATIONS;

(II) OFF-CAMPUS LOCATIONS BY HEALTH-CARE PROVIDERS AFFILIATED WITH OR OWNED BY A HOSPITAL OR HEALTH SYSTEM; AND

(III) LOCATIONS BY INDEPENDENT HEALTH-CARE PROVIDERS NOT AFFILIATED WITH OR OWNED BY A HOSPITAL SYSTEM.

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

(a) YEAR;

(b) HOSPITAL OR HEALTH SYSTEM, WHERE APPLICABLE;

(c) TYPE OF SERVICE;

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

(e) PAYER.

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

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

(10) A STATEWIDE ASSOCIATION OF HOSPITALS MAY ALSO PROVIDE DATA SPECIFIED IN SUBSECTION (6)(b) OF THIS SECTION TO THE STEERING COMMITTEE.

(11) THIS SECTION IS REPEALED, EFFECTIVE JANUARY 1, 2025.

SECTION 5. Appropriation - adjustments to 2023 long bill. (1) To implement this act, appropriations made in the annual general appropriation act for the 2023-24 state fiscal year to the department of health care policy and financing are adjusted as follows:

(a) The general fund appropriation for use by the executive director's office for personal services is increased by $18,326; and

(b) The general fund appropriation for use by the executive director's office for operating expenses is increased by $337.

(2) For the 2023-24 state fiscal year, the general assembly anticipates that federal funds received by the department of health care policy and financing will decrease by $18,663 to implement this act, which amount is subject to the "(I)" notation as defined in the annual general appropriation act for the same fiscal year. The appropriation in subsection (1) of this section is based on the assumption that the federal funds received by the department will decrease as follows:

(a) $18,326 for personal services; and

(b) $337 for operating expenses.

(3) For the 2023-24 state fiscal year, $516,950 is appropriated to the department of health care policy and financing for use by the executive director's office. This appropriation is from the general fund. To implement this act, the office may use this appropriation for general professional services and special projects.

SECTION 6. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, or safety.

Approved: May 30, 2023