Second Regular Session
Seventy-fourth General Assembly
STATE OF COLORADO

ENGROSSED
This Version Includes All Amendments Adopted on Second Reading in the House of Introduction

LLS NO. 24-0661.01 Shelby Ross x4510 **SENATE BILL 24-116**

SENATE SPONSORSHIP

Buckner,

HOUSE SPONSORSHIP

Jodeh,

Senate Committees
Health & Human Services
Appropriations

House Committees

A BILL FOR AN ACT

CONCERNING HEALTH-CARE BILLING FOR INDIGENT PATIENTS RECEIVING SERVICES NOT REIMBURSED THROUGH THE COLORADO INDIGENT CARE PROGRAM, AND, IN CONNECTION THEREWITH, MAKING AN 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.)

Current law requires a health-care facility to screen each uninsured patient for eligibility for public health insurance programs, discounted care through the Colorado indigent care program (CICP), and discounted

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.

SENATE
Amended 2nd Reading
April 25, 2024

care otherwise not reimbursed through the CICP. A patient qualifies for discounted care if the individual's household income is not more than 250% of the federal poverty level and the individual received a health-care service at a health-care facility (facility). The bill adds the requirement that a patient attest to residing in Colorado.

The licensed health-care professional who provides services to a patient is responsible for billing the patient for those services.

Current law prohibits a health-care facility and licensed health-care professional (professional) from collecting amounts charged that are more than 4% of the patient's monthly household income on a bill from a facility and that are more than 2% of the patient's monthly household income on a bill from each professional. The bill adds the requirement that a facility or professional cannot collect amounts charged that are more than 6% of the patient's household income on a comprehensive bill containing both facility and professional charges.

The bill authorizes a health-care facility to deny discounted care to a patient if, during the initial screening, the patient is determined to be presumptively eligible for medicaid.

The bill excludes primary care provided in a clinic that is located in a designated rural or frontier county and offers a sliding-fee scale from receiving discounted care.

Current law requires each facility to report to the department of health care policy and financing (department) data that the department determines is necessary to evaluate compliance across race, ethnicity, age, and primary-language-spoken patient groups with the screening, discounted care, payment plan, and collections practices. The bill requires professionals, in addition to facilities, to submit the data.

The bill authorizes a licensed or certified hospital to determine presumptive eligibility for medicaid.

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

SECTION 1. In Colorado Revised Statutes, 25.5-3-501, **amend** (5); **repeal** (4); and **add** (2.5) and (4.5) as follows:

25.5-3-501. Definitions. As used in this part 5, unless the context otherwise requires:

(2.5) "INPATIENT HOSPITAL SERVICE" HAS THE SAME MEANING AS SET FORTH IN 42 CFR 440.10.

(4) ~~"Non-CICP health-care services" means health-care services~~

~~provided in a health-care facility for which reimbursement under the Colorado indigent care program, established in part 1 of this article 3, is not available.~~

(4.5) "OUTPATIENT HOSPITAL SERVICE" HAS THE SAME MEANING AS SET FORTH IN 42 CFR 440.20.

(5) "Qualified patient" means an individual WHO ATTESTS TO RESIDING IN COLORADO whose household income is not more than two hundred fifty percent of the federal poverty level and who received ~~a~~ ~~health-care~~ AN INPATIENT HOSPITAL SERVICE OR OUTPATIENT HOSPITAL service at a health-care facility.

SECTION 2. In Colorado Revised Statutes, 25.5-3-503, **amend** (1) introductory portion, (1)(b), and (2)(a); and **add** (3) and (4) as follows:

25.5-3-503. Health-care discounts on services not eligible for Colorado indigent care program reimbursement - definition. (1) Beginning September 1, 2022, if a patient is screened pursuant to section 25.5-3-502 and is determined to be a qualified patient, a health-care facility and a licensed health-care professional shall, for emergency HOSPITAL and other ~~non-CICP~~ health-care services:

(b) Collect amounts charged, not including amounts owed by third-party payers, in monthly installments such that the patient is not paying more than four percent of the patient's monthly household income on a bill from a health-care facility, ~~and~~ not paying more than two percent of the patient's monthly household income on a bill from each licensed health-care professional, AND NOT PAYING MORE THAN SIX PERCENT OF THE PATIENT'S HOUSEHOLD INCOME ON A COMPREHENSIVE BILL CONTAINING ALL HEALTH-CARE FACILITY AND LICENSED HEALTH-CARE

PROFESSIONAL CHARGES; and

(2) A health-care facility shall not:

(a) Deny discounted care on the basis that the patient has not applied for any public benefits program, UNLESS DURING THE INITIAL SCREENING THE PATIENT IS DETERMINED TO BE PRESUMPTIVELY ELIGIBLE FOR THE STATE MEDICAL ASSISTANCE PROGRAM; or

(3) THE LICENSED HEALTH-CARE PROFESSIONAL WHO PROVIDES SERVICES TO A PATIENT PURSUANT TO THIS PART 5 IS RESPONSIBLE FOR BILLING THE PATIENT FOR THOSE SERVICES, UNLESS THE SERVICES ARE BILLED ON A COMPREHENSIVE BILL ISSUED BY A HEALTH-CARE FACILITY.

(4) FOR THE PURPOSES OF THIS PART 5, "EMERGENCY HOSPITAL AND OTHER HEALTH-CARE SERVICES" DOES NOT INCLUDE PRIMARY CARE PROVIDED IN A CLINIC LOCATED IN A DESIGNATED RURAL OR FRONTIER COUNTY THAT OFFERS A SLIDING-FEE SCALE AS APPROVED BY THE STATE DEPARTMENT.

SECTION 3. In Colorado Revised Statutes, 25.5-3-505, **amend** (1) as follows:

25.5-3-505. Health-care facility reporting requirements - agency enforcement - report - rules. (1) Beginning September 1, 2023, and each September 1 thereafter, each health-care facility AND LICENSED HEALTH-CARE PROFESSIONAL shall report to the state department data that the state department determines is necessary to evaluate compliance across race, ethnicity, age, and primary-language-spoken patient groups with the screening, discounted care, payment plan, and collections practices required pursuant to this part 5. If a health-care facility OR LICENSED HEALTH-CARE PROFESSIONAL is not capable of disaggregating the data required pursuant to this subsection (1) by race, ethnicity, age,

and primary language spoken, the health-care facility OR LICENSED HEALTH-CARE PROFESSIONAL shall report to the state department the steps the facility OR LICENSED HEALTH-CARE PROFESSIONAL is taking to improve race, ethnicity, age, and primary-language-spoken data collection and the date by which the facility OR LICENSED HEALTH-CARE PROFESSIONAL will be able to disaggregate the reported data.

SECTION 4. In Colorado Revised Statutes, 25.5-4-205, **amend** (1)(a) as follows:

25.5-4-205. Application - verification of eligibility - demonstration project - rules - repeal. (1) (a) Determination of eligibility for medical benefits shall be made by the county department in which the applicant resides, except as otherwise specified in this section. Local social security offices also determine eligibility for medicaid benefits at the same time ~~they determine~~ THE LOCAL SOCIAL SECURITY OFFICE DETERMINES eligibility for supplemental security income. The state department may accept medical assistance applications and determine medical assistance eligibility and may designate the private service contractor that administers the children's basic health plan, Denver health and ~~hospitals~~ HOSPITAL AUTHORITY, CREATED IN SECTION 25-29-103, a hospital that is designated as a regional pediatric trauma center, as defined in section 25-3.5-703 (4)(f), ~~C.R.S.,~~ and other medical assistance sites determined necessary by the state department to accept medical assistance applications, to determine medical assistance eligibility, and to determine presumptive eligibility. A HOSPITAL LICENSED PURSUANT TO PART 1 OF ARTICLE 3 OF TITLE 25 OR CERTIFIED PURSUANT TO SECTION 25-1.5-103 (1)(a)(II) IS AUTHORIZED TO DETERMINE PRESUMPTIVE ELIGIBILITY FOR MEDICAL ASSISTANCE PURSUANT TO 42

U.S.C. SEC. 1396a (a)(47)(B). When the state department determines that it is necessary to designate an additional medical assistance site, the state department shall notify the county in which the medical assistance site is located that an additional medical assistance site has been designated. ~~Any~~ A person who is determined to be eligible pursuant to the requirements of this ~~article~~ ARTICLE 4 and articles 5 and 6 of this ~~title shall be~~ TITLE 25.5 IS eligible for benefits until ~~such~~ THE person is determined to be ineligible. Upon determination that ~~any~~ A person is ineligible for medical benefits, the county department, the state department, or other entity designated by the state department shall notify the applicant in writing of its decision and the reason. ~~therefor.~~ When an applicant is found ineligible for medical assistance eligibility programs, the applicant's application data and verifications ~~shall~~ MUST be automatically shared with the state insurance marketplace through a system interface. Separate determination of eligibility and formal application for benefits ~~under~~ PURSUANT TO this ~~article~~ ARTICLE 4 and articles 5 and 6 of this ~~title~~ TITLE 25.5 for persons eligible ~~as provided in~~ PURSUANT TO sections 25.5-5-101 and 25.5-5-201 ~~shall~~ MUST be made in accordance with the rules of the state department.

SECTION 5. Appropriation. (1) For the 2024-25 state fiscal year, $154,598 is appropriated to the department of health care policy and financing for use by the executive director's office. This appropriation is from the health care affordability and sustainability fee cash fund created in section 25.5-4-402.4 (5)(a), C.R.S. To implement this act, the department may use this appropriation as follows:

(a) $135,747 for personal services, which amount is based on an assumption that the office will require an additional 3.4 FTE; and

(b) $18,851 for operating expenses.

(2) For the 2024-25 state fiscal year, the general assembly anticipates that the department of health care policy and financing will receive $154,597 in federal funds 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 department will receive this amount of federal funds to be used as follows:

(a) $135,746 for personal services; and

(b) $18,851 for operating expenses.

SECTION 6. 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.