

2017 LEGISLATIVE REPORT

**COLORADO
RURAL HEALTH
CENTER**

The State Office of Rural Health



Executive Summary

The 2017 state legislative session concluded on May 10th, 120 days after its start on January 11th, with rural Colorado winning big in the final days of state lawmaking. The state budget crisis and federal uncertainty made for a rocky start in January, a sentiment that continued through the six-month session. The General Assembly once again had split party control with Republicans controlling the Senate and Democrats controlling the House. The General Assembly also had many new members following the 2016 election, which presented a learning curve for new legislators to understand the policy making process and the state of Colorado as a whole. With these factors in mind, compromise was required for passage of any substantial legislation. Of the 681 bills introduced, 423 passed (62%). This compares to 2016 when 56% of 685 introduced bills passed and 2015 when 54% of 682 passed. The last time one party controlled both houses was 2014, when 72% of bills passed. Thus, the 2017 session has been called one of the more successful sessions of the split chamber era, with one party in control of each chamber since 2015.

In the first months of session, many legislators introduced ‘message bills,’ or bills not necessarily introduced with much hope for passage but rather introduced to convey a partisan principle. Republicans introduced many measures to repeal the health benefit exchange, curb government spending, loosen gun restrictions, and tighten regulations around abortion. Democrats introduced similar ill-fated partisan measures, such as banning gay-conversion therapy, making it easier to change a person’s gender on a birth certificate and reinstating mandated employer leave for parents seeking time off.

As the session continued and the budget crisis loomed, many pieces of legislation were introduced to remedy the perennial issue of the Hospital Provider Fee. Ultimately, SB17-267 Sustainability of Rural Colorado was the compromise bill that passed through the General Assembly in the final hours of session. The huge piece of legislation includes many provisions intended to provide rural Colorado with some fiscal and regulatory relief. The conversion of the Hospital Provider Fee into an Enterprise Fund is most notable for rural health professionals and advocates, as the accounting change avoided \$528 million in funding cuts for rural and safety net hospitals.

This report provides an overview of all legislation the Colorado Rural Health Center took a position on during the 120 day session. In total, CRHC either supported, opposed or monitored 21 pieces of legislation that have or would have impacted our membership. Seven of 11 bills CRHC supported passed and 1 of 3 bills CRHC opposed passed. CRHC took a position of Monitor on the remaining seven bills. The report is organized by bill category and includes an easy-to-read table and narrative on the legislation. You may click on the bill number to access more information, including the full bill text and fiscal note.

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1. Behavioral Health & Substance Abuse

Supported	
PASSED	NOT PASSED
SB17-146 Access To Prescription Drug Monitoring Program	HB17-1350 Pharmacist Partial Fill Opioid Prescription
Monitored	
SB17-193 Research Center Prevention Substance Abuse Addiction	

[SB17-146](#) Access To Prescription Drug Monitoring Program (PDMP)

CRHC Supported

Governor Signed (04/06/2017). This legislation applies to queries to the electronic prescription drug monitoring program occurring on or after the date of passage.

This legislation is one of many this session that attempts to tackle Colorado's opioid epidemic. Colorado ranks 2nd in the nation for prescription opioid abuse, and opioid-related overdose deaths in 2015 totaled 472, exceeding once again the number of homicides in the state. Lawmakers have been working hard to find solutions to the problem in the midst of a state budget crisis, and as such this legislation does not require any additional state funding. The bill modifies provisions relating to licensed health professionals' access to the electronic prescription drug monitoring program as follows:

- Allows a healthcare provider who has authority to prescribe controlled substances, or the provider's designee, to query the program regarding a current patient, regardless of whether the provider is prescribing or considering prescribing a controlled substance to that patient;
- Specifies that a veterinarian who is authorized to prescribe controlled substances may access the program to inquire about a current patient or client if the veterinarian suspects that the client has committed drug abuse or mistreated an animal; and
- Specifies that, in addition to accessing the program when dispensing or considering dispensing a controlled substance, a pharmacist or designee of the pharmacist may access the program regarding a current patient to whom the pharmacist is dispensing or considering dispensing a prescription drug.

The goal of the legislation is to allow providers greater access to the PDMP so they may make more holistic, 'total body' decisions about a drug and treatment plans. The legislation also adds veterinarians to the providers that may access the PDMP in response to the spike in pet owners intentionally injuring their pets to access their veterinary opioid prescriptions.

[SB17-193](#) **Research Center Prevention Substance Abuse Addiction**

CRHC Monitored

Governor Signed (05/24/2017) The \$1,000,000 appropriation for the research center is for the 2017-2018 budget and the research center will be subsequently developed.

The legislation establishes the center for research into prevention strategies for, and treatment of, abuse of and addiction to opioids, other controlled substances, and alcohol at the University of Colorado health sciences center. This bill makes an appropriation \$1,000,000 from the Marijuana Tax Cash Fund to the Department of Higher Education for use by the Regents of the University of Colorado.

The following legislation was postponed indefinitely:

[HB17-1350](#) **Pharmacist Partial Fill Opioid Prescription**

CRHC Supported

Senate Committee on State, Veterans, & Military Affairs Postponed Indefinitely (05/04/2017)

The bill would have allowed a pharmacist to dispense a schedule II opioid in a lesser amount than the prescribed amount, limited the time that the remaining portions of a partially filled prescription for a schedule II opioid may be filled, and directed the pharmacist that partially filled the drug to report the partial fill to the PDMP and retain the original prescription.

Bill proponents and sponsors pointed out that as many as 40% of opioid prescriptions go unfinished. The unused prescriptions may be stolen by opioid addicts or unknowingly improperly used. While the legislation was another strategy for curbing opioid abuse without a fiscal impact, the retail pharmacy chains and independent pharmacists felt the legislation put too much responsibility and liability on pharmacists. The legislation also had the potential for creating an access problem for rural Coloradans who already have to drive long distances to access prescriptions.

2. Billing, Payment & Reporting

Monitored	
PASSED	NOT PASSED
HB17-1139 Medicaid Provider Compliance Billing Safety Rules	
HB17-1353 Implement Medicaid Delivery & Payment Initiatives	
Opposed	
SB17-065 Transparency In Direct Pay Health Care Prices	HB17-1236 Health Care Policy And Financing Annual Report On Hospital Expenditures

[HB17-1139](#) Medicaid Provider Compliance Billing Safety Rules

CRHC Monitored

Sent to the Governor (05/18/2017)

The legislation requires a health care provider who improperly bills or seeks collection from a Medicaid client or his or her estate to refund any amount unlawfully received with interest, to pay a civil monetary penalty of \$100 for each violation, and makes the provider liable for all amounts submitted to a collection agency in the name of the Medicaid client. Bill proponents, including HCPF, purported that the legislation is only intended to ‘weed out bad apples’ and not punish healthcare providers who accidentally incorrectly bill. CRHC will monitor the implementation of this bill closely to understand how the state intends to define the ‘intent’ of the incorrect bill.

[HB17-1353](#) Implement Medicaid Delivery & Payment Initiatives

CRHC Monitored

Governor Signed (05/23/2017)

This Joint Budget Committee (JBC) bill adds the existing Medicaid Accountable Care Collaborative (ACC) to Colorado statute and authorizes performance payments to Medicaid providers. The legislation was developed in the face of federal uncertainty to ensure any progress made with the ACC and performance payments would not be derailed by changes in federal Medicaid funding or regulations.

In addition, the legislation requires HCPF to report to the legislature about the ACC by December 1, 2017, and each December 1 thereafter. HCPF is authorized to provide performance payments to primary care providers, federally qualified health centers, providers of long-term services and supports, and behavioral health service providers. Prior to implementing performance payments, HCPF must submit evidence that performance-based payments are designed to achieve budget savings or a budget request for any associated costs. The Request For Proposals for ACC Phase II was released May 11, 2017.

[SB17-065](#) Transparency In Direct Pay Health Care Prices

CRHC Opposed

Governor Signed (04/06/2017), legislation takes effect January 1, 2018.

The legislation creates the Transparency in Health Care Prices Act, which requires health care professionals and health care facilities to make available to the public the health care prices they assess directly for common health care services they provide. Healthcare price is defined in the legislation as the price, before negotiating any discounts, that a healthcare provider or healthcare facility will charge a recipient of healthcare services rendered.

All healthcare facilities must make available, whether on their website or on a single document placed in a conspicuous waiting room setting, the healthcare prices for at least the top 15 most common healthcare services the providers provides. If the provider regularly provides fewer than 15 healthcare services, they must make available healthcare prices for the most commonly provided services. A healthcare provider practicing in a solo practice, in a medical group, independent practice association or professional corporation comprised of no more than 6 individual healthcare providers with the same license may comply with the requirements by making the healthcare prices available in patient waiting areas.

Healthcare providers must update the document at least annually. The document must also include a disclosure specifying that the healthcare price for any given healthcare service is an estimate and that the actual charges for the healthcare service are dependent on the circumstances at the time the services are rendered. The following statement or a statement containing similar information must also be included:

“If you are covered by health insurance, you are strongly encouraged to consult with your health insurer to determine accurate information about your financial responsibility for a particular healthcare service provided by a healthcare provider at this office. If you are not covered by health insurance, you are strongly encouraged to contact our billing office at

(INSERT PHONE NUMBER) to discuss payment options prior to receiving a healthcare service from a healthcare provider at this office since posted healthcare process may not reflect the actual amount of you financial responsibility."

Health care professionals and facilities are not required to submit their health care prices to any government agency for review or approval. Additionally, the act prohibits health insurers, government agencies, or other persons or entities from penalizing a health care recipient, provider, facility, employer, or other person or entity who pays directly for health care services or otherwise exercises rights under or complies with the act.

The following legislation was postponed indefinitely:

[HB17-1236](#) Health Care Policy and Financing (HCPF) Annual Report on Hospital Expenditures

CRHC Opposed

Senate Committee on State, Veterans, & Military Affairs Postponed Indefinitely (04/24/2017)

The legislation would have required HCPF prepare an annual report detailing the cost of uncompensated care provided by general hospitals in Colorado. The bill specified the information that hospitals would be required to submit.

3. Budget & Fiscal Issues

Supported	
PASSED	NOT PASSED
SB17-267 Sustainability Of Rural Colorado	SB17-057 Colorado Healthcare Affordability & Sustainability Enterprise
	HB17-1187 Change Excess State Revenues Cap Growth Factor

[SB17-267](#) Sustainability of Rural Colorado

CRHC Supported

Governor Signed (05/30/2017), legislation takes effect July 1, 2017

Many pieces of legislation were introduced to remedy the perennial issue of the Hospital Provider Fee. Ultimately, SB17-267 Sustainability of Rural Colorado was the compromise bill that passed through the General Assembly in the final hours of session. The huge piece of legislation includes many provisions intended to provide rural Colorado with some fiscal and regulatory relief. The conversion of the Hospital Provider Fee into an Enterprise Fund is most notable for rural health professionals and advocates, as the accounting change avoided \$528 million in funding cuts for rural and safety net hospitals. The bill also provides:

- \$1.88 billion over 20 years for rural transportation needs
- \$200 million reduction in the Taxpayer’s Bill of Rights spending cap (limiting government spending even more than where voters set it with Referendum C in 2005)
- \$20 million in tax credits in 2019-20 for Colorado businesses to offset the loathsome business personal property tax
- \$40 million in increased marijuana taxes by raising the special sales tax to 15 percent in 2017-18
- \$30 million for rural schools in 2017-18
- \$20 million for all K-12 schools in 2018-19 and 2019-20

Additionally, it requires every state agency to present a budget next year that proposes an optional 2 percent reduction in funding.

The following legislation was intended to address the Hospital Provider Fee enterprise fund and subsequent cuts to rural healthcare facilities, but was postponed indefinitely:

[SB17-057](#) Colorado Healthcare Affordability & Sustainability Enterprise

CRHC Supported

Senate Committee on Finance Postponed Indefinitely (03/21/2017)

The legislation would have converted the Hospital Provider Fee into an Enterprise fund with the creation the Colorado Healthcare Affordability and Sustainability enterprise. The fund would have operated as a type 2 agency and government-owned business within HCPF. *Note the Hospital Provider Fee Enterprise Fund created by SB17-267 will operate in the same manner as described in this legislation.

[HB17-1187](#) Change Excess State Revenues Cap Growth Factor

CRHC Supported

Senate Committee on State, Veterans, & Military Affairs Postponed Indefinitely (03/20/2017)

The legislation would have required an approval by Colorado voters and would have changed how the TABOR cap is calculated. Currently, the excess state revenues cap is adjusted annually for inflation and population changes, among other things. The bill would have modified the excess state revenues cap by allowing an annual adjustment for an increase based on the average annual change of Colorado personal income over the last 5 years rather than adjusting for inflation and population.

4. Healthcare Delivery & Scope of Practice

Supported	
PASSED	NOT PASSED
SB17-033 Delegate Dispensing Over-the-counter Medications	
HB17-1115 Direct Primary Health Care Services	
HB17-1057 Interstate Physical Therapy Licensure Compact	
Monitored	
	SB17-064 License Freestanding Emergency Departments

[SB17-033](#) Delegate Dispensing Over-the-counter (OTC) Medications

CRHC Supported

Governor signed 3/30/17, legislation goes into effect on August 9, 2017.

The bill allows a professional nurse to delegate to another person, after appropriate training, the dispensing authority of an over-the-counter medication to a minor with the signed consent of the minor's parent or guardian. Before this legislation, only Physicians and APNs could delegate OTC medications for minors. This presented an issue for school nurses, especially in rural areas, who did not have the authority to instruct teachers how to administer OTC medications to students off-campus.

[HB17-1115](#) Direct Primary Health Care Services

CRHC Supported

Governor Signed (04/24/2017), legislation goes into effect on August 9, 2017.

The legislation establishes parameters under which a direct primary care agreement may be implemented. An agreement may be entered into between a direct primary health care provider and a patient for the payment of a periodic fee and for a specified period of time. The provider must be a licensed, registered, or certified individual or entity authorized to provide primary care services.

The bill establishes that the agreement is not the business of insurance or the practice of underwriting and does not fall under regulation of the Division of Insurance. The bill outlines the conditions under which a provider may discontinue care to a patient.

The direct primary care is a model similar to a gym membership. Patients sign up with a primary care provider for a predetermined monthly fee in exchange for unlimited primary care services. Advocates of the direct primary care model say it allows providers to spend more time taking care of patients and less time completing paperwork and dealing with billing. The direct primary care service model may serve as an alternative revenue source for already struggling rural health clinics, and may also fill in primary care service gaps for rural patients when used in conjunction with a high-deductible insurance plan. Because the bill is explicitly not insurance, certified Rural Health Clinics may participate in the DPC model if they develop a dual system for DPC billing and fee-for-service billing. The direct primary care model serves as another tool in the toolkit for addressing rural healthcare issues, and ultimately improving the overall health and economic well-being of rural Colorado communities.

[HB17-1057](#) Interstate Physical Therapy Licensure Compact

CRHC Supported

Governor Signed (05/10/2017)

The legislation enacts the Interstate Physical Therapy Licensure Compact Act and requires the Governor to enter into the compact on behalf of Colorado. Under the compact, physical therapists and physical therapy assistants licensed or certified in a compact member state may obtain an expedited license or certificate allowing them to practice in another compact member state. The compact will be administered by the

Physical Therapy Compact Commission which will process applications for compact participation. Licensed physical therapists and certified physical therapy assistants in Colorado and other member states are granted "compact privileges," which allows them to practice as a physical therapist or work as a physical therapy assistant in another member state under the laws and rules of the remote state. To exercise the compact privilege, a licensee or certificate holder, must:

- hold a license or certificate in the home state with no encumbrances;
- be eligible for a compact privilege in any member state;
- have no adverse actions within the previous two years;
- notify the commission that compact privilege is being sought in a member state;
- pay applicable fees;
- be aware of the laws and rules governing the practice of physical therapy in the remote state; and
- report adverse action taken by any non-member state within 30 days

The following legislation was postponed indefinitely:

[SB17-064](#) License Freestanding Emergency Departments

CRHC Monitored

Senate Committee on State, Veterans, & Military Affairs Postponed Indefinitely (02/08/2017)

The legislation would have required freestanding emergency departments to be licensed under a newly created license type from CDPHE by July 1, 2019. Under current law, these facilities are licensed as community clinics with emergency centers. From the effective date of the bill until the required license date, no new freestanding emergency departments could be licensed under the new or existing license types, and facilities that meet the definition of freestanding emergency department and are currently licensed as a community clinic would have to comply with the additional financial and facility regulations.

A freestanding emergency department would also be required to develop procedures for triaging patients upon intake to determine whether emergency or urgent care is needed, and if no medical emergency exists, the freestanding emergency department must be able to provide urgent care and bill patients at the lower urgent care rate. The bill would require CDPHE to establish various rules for freestanding emergency departments, including licensing; fees; staffing requirements; transfer and transportation protocols; **location restrictions near critical access hospitals**; and transparency requirements for facility fees, professional fees, and fees for ancillary services.

5. Insurance Coverage, Regulations & Affordability

Supported	
PASSED	NOT PASSED
HB17-1094 Telehealth Coverage Under Health Benefit Plans	HB17-1247 Patient Choice Health Care Provider
Monitored	
	SB17-206 Out-of-network Providers Payments Patient Notice
	HB17-1237 State Employee Group Benefit Plans For Local Government
Opposed	
	SB17-003 Repeal Colorado Health Benefit Exchange

[HB17-1094](#) Telehealth Coverage Under Health Benefit Plans

CRHC Supported

Governor Signed (03/16/2017), legislation took effect upon passage and applies to health benefit plans issues or renewed on or after said date.

This legislation is a “clean-up bill” intended to further clarify the telehealth coverage legislation passed in the 2016 state legislation session. Under current law, health benefit plans are required to cover health care services delivered to a covered person by a provider via telehealth in the same manner that the plan covers health care services delivered by a provider in person. The bill clarifies that:

- A health plan cannot restrict or deny coverage of telehealth services based on the communication technology or application used to deliver the telehealth services;
- The availability of telehealth services does not change a carrier's obligation to contract with providers available in the community to provide in-person services who are willing to negotiate reasonable contract terms with the carrier;
- A covered person may receive telehealth services from a private residence, but the carrier is not required to pay for transmission costs the covered person incurs; and
- Telehealth includes health care services provided through audio-visual communication or the use of a HIPAA-compliant application via a cellular telephone but does not include voice-only telephone communication or text messaging.

The following legislation was postponed indefinitely:

[HB17-1247](#) Patient Choice Health Care Provider

CRHC Supported

House Committee on Health, Insurance, & Environment Postponed Indefinitely (04/13/2017)

The legislation would have prohibited a health benefit plan or third-party administrator plan covering services by licensed chiropractors, optometrists, or pharmacists from:

- Limiting or restricting a covered person's ability to select a provider of the covered person's choice if certain conditions are met;
- Imposing a copayment, fee, or other cost-sharing requirement for selecting a provider of the covered person's choosing;
- Imposing other conditions on a covered person or provider that limit or restrict a covered person's ability to use a pharmacy of the covered person's choosing; or
- Denying a provider the right to participate in any of its network contracts in this state or as a contracting provider in this state, so long as the provider agrees to specified conditions.

[SB17-206](#) Out-of-network Providers Payments Patient Notice

CRHC Monitored

Senate Committee on Business, Labor, & Technology Postponed Indefinitely (04/10/2017)

The legislation outlined a method for a health insurer to use in determining the amount it must pay an out-of-network provider that rendered covered services to a covered person at an in-network facility and requires the health insurer to pay the out-of-network provider directly. The bill also would have established an independent dispute resolution process by which an out-of-network provider may obtain review of a payment from a health insurer.

Under current law, when a health care provider who is not under a contract with a health insurer (out-of-network provider) renders health care services to a person covered under a health benefit plan at a facility that is part of the provider network under the plan (in-network facility), the health insurer is required to cover the services of the out-of-network provider at the in-network benefit level and at no greater cost to the covered person than if the services were provided by an in-network provider.

The bill was killed in committee as health insurers and providers were unable to come to agreement. It was also noted that the Department of Insurance is already engaging in a pilot program similar to the legislation, and any outcomes or information gleaned from the pilot program may inform similar legislation in the future.

[HB17-1237](#) State Employee Group Benefit Plans For Local Government

CRHC Monitored

Senate Committee on State, Veterans, & Military Affairs Postponed Indefinitely (05/03/2017)

The legislation would have allowed local governments (municipalities, counties, city and counties, special districts, school districts, and any other subdivision of the state) to provide health benefits to their employees through the state employee group benefit plans.

Bill sponsors and proponents, included Lieutenant Governor Donna Lynne, claimed the bill would increase benefits and lower costs, and noted half of US states already offer this option. Supporters claimed that adding more people to the state employee insurance pool would drive down costs and offer multiple carriers and plans to give participants options. Supporters also noted that people are not required to participate, so if the state-offered plan was more expensive or would be inaccessible, people could opt out.

Opponents claimed the legislation would ultimately damage healthcare accessibility in rural Colorado. Local governments are huge employers and usually already have pretty good coverage, and that adding them to the state plan will put a disproportionate share of people with Kaiser or United.

There are not adequate networks in rural with these carriers, and there is nothing in the bill that would require them to do so. This could force providers to either accept poor reimbursement or lose the well-insured patients. Rural hospital leaders claimed if people with private insurance have to leave their communities to find in-network providers, rural hospitals will have even higher proportions of Medicaid and Medicare. This will threaten their sustainability, as rural healthcare providers need private pay in their payer mix to also be able to serve higher rates of Medicare and Medicaid.

[SB17-003](#) Repeal Colorado Health Benefit Exchange

CRHC Opposed

Senate second reading laid over (5/8/2017) vote subsequently expired

The legislation would have repealed the state's health insurance exchange, Connect for Health Colorado, on January 1, 2018. Connect for Health Colorado would have had one year to wind-down its operations, at which point any unencumbered funds would be transferred to

the state General Fund. With the repeal of Connect for Health Colorado, the bill would also repeal the legislative oversight committee for the health exchange and the premium tax credit for contributions made to Connect for Health Colorado. 39,950 rural Coloradans purchased health insurance through the state exchange and would have had to find healthcare coverage elsewhere. Statewide, 25% of Coloradans who purchased coverage through the exchange are between the ages of 55-60, and over 55% of Coloradans enrolled with the exchange qualified to receive financial assistance through tax credits.

6. Workforce & Economic Development

Supported	
PASSED	NOT PASSED
SB17-137 Sunset Health Service Corps Advisory Council	
Monitored	
	HB17-1121 Patient Safety Act

[SB17-137](#) Sunset Health Service Corps Advisory Council

CRHC Supported

Governor Signed (04/18/2017), legislation took effect upon passage.

The Colorado health service corps advisory council reviews applications and makes recommendations for participation in the Colorado health service corps program. The program awards educational loan repayment for medical professionals who agree to provide primary health services in federally designated health professional shortage areas in Colorado. The bill continues the Colorado health service corps advisory council indefinitely and no longer requires the advisory council be renewed via the legislature. CRHC is active with the council and our provider recruit program provides technical assistance and educates providers interested in working in rural Colorado about the loan repayment program.

The following legislation was postponed indefinitely:

[HB17-1121](#) Patient Safety Act

CRHC Monitored

Senate Committee on State, Veterans, & Military Affairs Postpone Indefinitely (05/04/2017)

The legislation would have required current and future licensees or certificate holders in the following professions to submit a criminal history record check: podiatrists, dentists and dental hygienists, medical doctors, physician assistants, anesthesiologists, nurses, certified nurse aides, optometrists and veterinarians. Based on the finding of the criminal history record check, DORA could have denied licensure or certification for certain criminal charges.