

Second Regular Session  
Seventy-fifth General Assembly  
STATE OF COLORADO

**ENGROSSED**

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

LLS NO. 26-0721.01 Josh Schultz x5486

**SENATE BILL 26-138**

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**SENATE SPONSORSHIP**

**Daugherty and Mullica,**

**HOUSE SPONSORSHIP**

**Stewart K.,**

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**Senate Committees**

Health & Human Services  
Appropriations

**House Committees**

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**A BILL FOR AN ACT**

101 **CONCERNING MEASURES TO REDUCE THE ADMINISTRATIVE BURDEN ON**  
102 **THE HEALTH-CARE SYSTEM.**

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**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>.)*

**Section 2** of the bill requires the commissioner of insurance (commissioner) to conduct a performance audit of all division of insurance (division) rules related to health care on or before January 1, 2029, and at least once every 5 years thereafter. Commencing January 2029, and every 5 years thereafter, the division shall report on the findings of the audit during its "SMART Act" hearing.

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 30, 2026

**Section 3** repeals provisions that require health insurance carriers (carriers) to comply with federal price transparency laws and to make available an internet-based self-service tool that provides real-time responses to a covered person's questions concerning carrier prices that are based on cost-sharing information.

**Section 3** also repeals a requirement that carriers submit information required by federal pharmacy benefit and drug cost reporting laws to the commissioner and make certain information regarding price transparency publicly available.

**Section 4** repeals a requirement that health-care profession regulators adopt rules that require each licensed health-care provider, as a condition of renewing, reactivating, or reinstating a license, to complete up to 4 credit hours of training per licensing cycle in order to demonstrate competency regarding topics related to prescribing drugs and treatment.

**Section 5** changes the frequency that specific health-care facilities are required to apply for a license issued by the department of public health and environment from annually to every 2 years.

**Section 6** requires the department of health care policy and financing (state department) to conduct a performance audit of all state department rules related to health care on or before January 1, 2029, and at least once every 5 years thereafter. Commencing January 2029, and every 5 years thereafter, the state department shall report on the findings of the audit during its "SMART Act" hearing.

Under current law, a health-care facility is required to screen each uninsured patient for eligibility for public health insurance programs and discounted care (screening) utilizing a single uniform application developed by the state department. **Sections 7 through 12** change these requirements in the following ways:

- Changing the method used to conduct the screening from a uniform application to use of a third-party resource, such as a major credit bureau, or use of a uniform screening questionnaire (questionnaire) developed by the state department;
- Allowing a health-care facility the option of screening a patient for eligibility for the health-care facility's financial assistance program;
- Requiring a health-care facility to provide specified notifications upon completion of the screening;
- Creating an application for discounted care (application) for use by a health-care facility upon completion of the screening through which additional information is requested from a patient to enable the health-care facility to determine whether the patient has qualified or is likely to qualify for public health-care coverage or discounted care;

- Requiring a health-care facility to provide specified notice and appeal rights to a patient upon completion and review of the application; and
- Requiring the state department to adopt rules regarding the questionnaire and application.

**Section 12** also narrows state department review requirements of health-care facilities' and licensed health-care professionals' billing for patients who are indigent. The bill prohibits the state department from making changes to regulatory documents or imposing new requirements unless the changes or new requirements are adopted by rule by specified dates and are subject to stakeholder engagement.

**Section 13** requires the state department to establish the content and format of the information each hospital must provide to the state department for a hospital transparency report by rule at least 30 days prior to the hospital's fiscal year. Current law requires that each hospital has a minimum of 15 days to review the hospital transparency report; the bill requires that a statewide hospital association must also have a minimum of 15 days to review the report.

**Sections 14 through 17** make conforming amendments.

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

2 **SECTION 1. Legislative declaration.** (1) The general assembly  
 3 finds and declares that:

4 (a) Every Colorado family deserves a fair, dignified, and  
 5 understandable path to financial assistance when seeking health care.  
 6 Patients benefit from hospitals' discounted care programs and these  
 7 programs increase access to affordable care. Reducing duplication and  
 8 confusion in navigating the process for both patients and health-care  
 9 providers is essential to ensure the process does not create barriers for the  
 10 very people the law was intended to help.

11 (b) Rising insurance premiums and the impacts of H.R. 1 of the  
 12 119th congress (2025-2026), Pub.L. 119-21, are likely to increase the  
 13 number of uninsured and underinsured Coloradans seeking discounted  
 14 care. At a time when more families are struggling to afford basic

1 health-care services, Colorado must ensure that access to financial relief  
2 is simple, timely, and centered on the needs of patients.

3 (c) It is the intent of the general assembly to reduce unnecessary  
4 paperwork, eliminate avoidable burdens, and create a process that  
5 respects people's time, circumstances, and dignity. Streamlining and  
6 clarifying these pathways will allow health-care providers to focus more  
7 resources on helping families instead of on navigating shifting rules or  
8 administrative obstacles.

9 (d) The general assembly affirms that all patient rights, including  
10 the right to appeal and to provide information demonstrating eligibility  
11 for public health-care coverage or discounted care, must remain fully  
12 protected; and

13 (e) This act strengthens the promise that discounted care in our  
14 state will be accessible and rooted in compassion.

15 **SECTION 2.** In Colorado Revised Statutes, **amend 12-30-114 as**  
16 follows:

17 **12-30-114. Demonstrated competency - repeal of rules -**  
18 **repeal.**

19 (1) (a) ~~The regulator for each licensed health-care provider, in~~  
20 ~~consultation with the center for research into substance use disorder~~  
21 ~~prevention, treatment, and recovery support strategies created in section~~  
22 ~~27-80-118, shall promulgate rules that require each licensed health-care~~  
23 ~~provider, as a condition of renewing, reactivating, or reinstating a license~~  
24 ~~on or after October 1, 2022, to complete up to four credit hours of~~  
25 ~~training per licensing cycle in order to demonstrate competency~~  
26 ~~regarding:~~

27 (I) ~~Best practices for opioid prescribing, according to the most~~

1 recent version of the division's guidelines for the safe prescribing and  
2 dispensing of opioids;

3 (II) The potential harm of inappropriately limiting prescriptions  
4 to chronic pain patients;

5 (III) Best practices for prescribing benzodiazepines;

6 (IV) Recognition of substance use disorders;

7 (V) Referral of patients with substance use disorders for  
8 treatment; and

9 (VI) The use of the electronic prescription drug monitoring  
10 program created in part 4 of article 280 of this title 12.

11 (b) The rules promulgated by each regulator shall exempt a  
12 licensed health-care provider who:

13 (I) Maintains a national board certification that requires equivalent  
14 substance use prevention training; or

15 (II) Attests to the regulator that the health-care provider does not  
16 prescribe opioids.

17 (2) For the purposes of this section, "licensed health-care  
18 provider" includes any of the following providers who are licensed  
19 pursuant to this title 12:

20 (a) A physician;

21 (b) A physician assistant;

22 (c) A podiatrist;

23 (d) A dentist;

24 (e) An advanced practice registered nurse or certified midwife  
25 with prescriptive authority;

26 (f) An optometrist; and

27 (g) A veterinarian.

1           (3) EACH REGULATOR THAT ADOPTED RULES PURSUANT TO THIS  
2           SECTION BEFORE THE EFFECTIVE DATE OF THIS SUBSECTION (3), WHICH  
3           RULES REQUIRE A LICENSED HEALTH-CARE PROVIDER, AS A CONDITION OF  
4           RENEWING, REACTIVATING, OR REINSTATING A LICENSE, TO COMPLETE UP  
5           TO FOUR CREDIT HOURS OF TRAINING PER LICENSING CYCLE IN ORDER TO  
6           DEMONSTRATE OPIATE PRESCRIBER COMPETENCY SHALL REPEAL THE  
7           RULES ON OR BEFORE JULY 1, 2027.

8           (4) THIS SECTION IS REPEALED, EFFECTIVE SEPTEMBER 1, 2029.

9           **SECTION 3.** In Colorado Revised Statutes, 12-220-308, **add (3)**  
10          as follows:

11           **12-220-308. Continuing education requirements - rules.**

12           (3) (a) THE BOARD MAY ADOPT RULES REQUIRING EVERY DENTIST,  
13           DENTAL THERAPIST, AND DENTAL HYGIENIST, AS CONDITION OF RENEWING,  
14           REACTIVATING, OR REINSTATING A LICENSE ISSUED UNDER THIS ARTICLE  
15           220, TO COMPLETE UP TO FOUR CREDIT HOURS OF TRAINING PER LICENSING  
16           CYCLE REGARDING:

17           (I) BEST PRACTICES FOR OPIOID PRESCRIBING;

18           (II) BEST PRACTICES FOR BENZODIAZEPINE PRESCRIBING;

19           (III) RECOGNITION OF SUBSTANCE USE DISORDERS;

20           (IV) REFERRAL OF PATIENTS WITH SUSPECTED SUBSTANCE USE  
21           DISORDERS FOR TREATMENT; AND

22           (V) THE USE OF THE ELECTRONIC PRESCRIPTION DRUG MONITORING  
23           PROGRAM CREATED IN PART 4 OF ARTICLE 280 OF THIS TITLE 12.

24           (b) REGARDLESS OF WHETHER THE BOARD ADOPTS RULES TO  
25           REQUIRE TRAINING PURSUANT TO SUBSECTION (3)(a) OF THIS SECTION, IF  
26           A LICENSED DENTIST, DENTAL THERAPIST, OR DENTAL HYGIENIST  
27           COMPLETES TRAINING REGARDING OPIOID PRESCRIBER COMPETENCY, THE

1 BOARD SHALL COUNT UP TO FOUR HOURS OF SUCH TRAINING TOWARD THE  
2 LICENSEE'S CONTINUING EDUCATION REQUIRED BY SUBSECTION (1) OF THIS  
3 SECTION.

4 **SECTION 4.** In Colorado Revised Statutes, 12-315-110, **add**  
5 **(3)(d), (3)(e), and (3)(f) as follows:**

6 **12-315-110. License renewal - waiver - rules - continuing**  
7 **education.**

8 (3)(d) A LICENSED VETERINARIAN SHALL COMPLETE AT LEAST ONE  
9 HOUR OF TRAINING REGARDING SUBSTANCE USE PREVENTION PER  
10 RENEWAL PERIOD TO DEMONSTRATE COMPETENCY REGARDING:

11 (I) BEST PRACTICES FOR VETERINARY OPIOID PRESCRIBING;

12 (II) BEST PRACTICES FOR VETERINARY BENZODIAZEPINE  
13 PRESCRIBING;

14 (III) RECOGNITION OF HUMAN SUBSTANCE USE DISORDERS;

15 (IV) REFERRAL OF HUMANS WITH SUSPECTED SUBSTANCE USE  
16 DISORDERS FOR TREATMENT; AND

17 (V) THE USE OF THE ELECTRONIC PRESCRIPTION DRUG MONITORING  
18 PROGRAM CREATED IN PART 4 OF ARTICLE 280 OF THIS TITLE 12.

19 (e) SUBSECTION (3)(d) OF THIS SECTION DOES NOT APPLY TO A  
20 LICENSED VETERINARIAN WHO:

21 (I) MAINTAINS A NATIONAL BOARD CERTIFICATION THAT REQUIRES  
22 EQUIVALENT SUBSTANCE USE PREVENTION TRAINING; OR

23 (II) ATTESTS TO THE BOARD THAT THE LICENSED VETERINARIAN  
24 DOES NOT PRESCRIBE OPIOIDS.

25 (f) THE BOARD SHALL ADOPT RULES TO IMPLEMENT SUBSECTIONS  
26 (3)(d) AND (3)(e) OF THIS SECTION.

27 **SECTION 5.** In Colorado Revised Statutes, 25-3-102, **amend**

1 (1)(a); and repeal (1)(d) as follows:

2 **25-3-102. License - application - issuance - waiver - certificate**  
3 **of compliance required - rules.**

4 (1) (a) (I) An applicant for a license described in section 25-3-101  
5 shall apply to the department of public health and environment annually  
6 EVERY TWO YEARS upon such form and in such manner as prescribed by  
7 the department; except that a community residential home shall make  
8 application for a license pursuant to section 25.5-10-214. C.R.S.

9 (II) ON OR BEFORE JULY 1, 2030, NOTWITHSTANDING SUBSECTION  
10 (1)(a)(I) OF THIS SECTION, THE DEPARTMENT MAY ISSUE A LICENSE  
11 DESCRIBED IN SECTION 25-3-101 TO AN APPLICANT AND REQUIRE THE  
12 APPLICANT TO APPLY TO THE DEPARTMENT AFTER A ONE-YEAR PERIOD AS  
13 THE DEPARTMENT DEEMS APPROPRIATE.

14 (d) ~~The license expires one year after the date of issuance.~~

15 **SECTION 6. In Colorado Revised Statutes, 25.5-3-501, amend**  
16 **(6); and add (6.7) as follows:**

17 **25.5-3-501. Definitions.**

18 As used in this part 5, unless the context otherwise requires:

19 (6) "Screen" or "screening" means a process identified in rule by  
20 the state department DESCRIBED IN SECTION 25.5-3-502 whereby  
21 health-care facilities assess a patient's circumstances related to eligibility  
22 criteria and determine whether the patient HAS QUALIFIED OR is likely to  
23 qualify for public health-care coverage or discounted care AND, AT THE  
24 OPTION OF THE HEALTH-CARE FACILITY, IS ELIGIBLE OR IS LIKELY ELIGIBLE  
25 FOR THE HEALTH-CARE FACILITY'S FINANCIAL ASSISTANCE PROGRAM;  
26 inform the patient of the health-care facility's determination; and provide  
27 information to the patient about how the patient can enroll in public

1 health-care coverage OR THE HEALTH-CARE FACILITY'S FINANCIAL  
2 ASSISTANCE PROGRAM.

3 (6.7) "UNIFORM APPLICATION" OR "APPLICATION" MEANS A  
4 UNIFORM FORM THAT IS DEVELOPED BY THE STATE DEPARTMENT TO  
5 DETERMINE WHETHER A PATIENT IS A QUALIFIED PATIENT AND IS  
6 COMPLETED FOLLOWING A SCREENING OR WHEN REQUIRED BY SECTION  
7 25.5-3-502.5.

8 **SECTION 7.** In Colorado Revised Statutes, **amend 25.5-3-502**  
9 as follows:

10 **25.5-3-502. Requirement to screen patients for eligibility for**  
11 **financial assistance - questionnaire - definition - rules.**

12 (1) Beginning September 1, 2022, a health-care facility shall  
13 screen, unless a patient declines, each uninsured patient for eligibility for:

14 (a) Public health insurance programs, including but not limited to  
15 medicare; the state medical assistance program DESCRIBED IN articles 4,  
16 5, and 6 of this title 25.5; emergency medicaid; and the children's basic  
17 health plan DESCRIBED IN article 8 of this title 25.5; and

18 ~~(b) Repealed.~~

19 ~~(c) (b) Discounted care, as described in section 25.5-3-503; AND~~

20 ~~(c) AT THE OPTION OF THE HEALTH-CARE FACILITY, THE~~  
21 ~~HEALTH-CARE FACILITY'S FINANCIAL ASSISTANCE PROGRAM, WHICH OFTEN~~  
22 ~~OFFERS BROADER ELIGIBILITY THAN PUBLIC HEALTH INSURANCE~~  
23 ~~PROGRAMS.~~

24 (2) Health-care facilities shall use a single uniform application  
25 developed by the state department when screening a patient pursuant to  
26 subsection (1) of this section. A HEALTH-CARE FACILITY MAY CONDUCT  
27 SCREENINGS PURSUANT TO SUBSECTION (1) OF THIS SECTION THROUGH:

1           (a) ACCESSING ELIGIBILITY INFORMATION THROUGH AN  
2 INDUSTRY-STANDARD THIRD-PARTY RESOURCE, SUCH AS A MAJOR CREDIT  
3 BUREAU;

4           (b) REQUESTING THE PATIENT COMPLETE A UNIFORM SCREENING  
5 QUESTIONNAIRE DEVELOPED BY THE STATE DEPARTMENT; OR

6           (c) A COMBINATION OF INFORMATION OBTAINED THROUGH  
7 SUBSECTIONS (2)(a) AND (2)(b) OF THIS SECTION.

8           (3) If a health-care facility determines that a patient is ineligible  
9 for discounted care, the facility shall provide the patient notice of the  
10 determination and an opportunity for the patient to appeal the  
11 determination in accordance with state department rules IF A  
12 HEALTH-CARE FACILITY DETERMINES IT HAS OBTAINED SUFFICIENT  
13 INFORMATION THROUGH THE SCREENING CONDUCTED PURSUANT TO  
14 SUBSECTION (1) OF THIS SECTION, THE HEALTH-CARE FACILITY MAY MAKE  
15 A DETERMINATION OF WHETHER THE PATIENT IS A QUALIFIED PATIENT OR  
16 IS LIKELY ELIGIBLE FOR PUBLIC HEALTH-CARE COVERAGE WITHOUT  
17 REQUIRING THE PATIENT TO PROVIDE FURTHER INFORMATION THROUGH A  
18 UNIFORM APPLICATION PURSUANT TO SECTION 25.5-3-502.5.

19           (3.5) UPON COMPLETION OF THE SCREENING CONDUCTED  
20 PURSUANT TO SUBSECTION (1) OF THIS SECTION, A HEALTH-CARE FACILITY  
21 SHALL:

22           (a) IF THE HEALTH-CARE FACILITY DETERMINES THAT A PATIENT  
23 IS A QUALIFIED PATIENT, PROVIDE THE PATIENT NOTICE OF THE  
24 DETERMINATION, THE PATIENT'S IDENTIFIED FEDERAL POVERTY GUIDELINE  
25 PERCENTAGE, AND THE PATIENT'S MONTHLY INSTALLMENT MAXIMUM  
26 PAYMENT AS DESCRIBED IN SECTION 25.5-3-503;

27           (b) IF THE HEALTH-CARE FACILITY DETERMINES THAT A PATIENT

1 IS LIKELY NOT A QUALIFIED PATIENT, INFORM THE PATIENT OF THE  
2 RESULTS OF THE SCREENING AND PROVIDE THE PATIENT WITH:

3 (I) INFORMATION ON HOW TO COMPLETE AN APPLICATION  
4 PURSUANT TO SECTION 25.5-3-502.5; AND

5 (II) IF APPLICABLE, AT THE OPTION OF THE HEALTH-CARE FACILITY,  
6 INFORMATION REGARDING THE PATIENT'S ELIGIBILITY FOR THE  
7 HEALTH-CARE FACILITY'S FINANCIAL ASSISTANCE PROGRAM AND THE  
8 AMOUNT OF ANY DISCOUNT OFFERED THROUGH THE PROGRAM;

9 (c) IF THE HEALTH-CARE FACILITY IS CERTIFIED BY THE STATE  
10 DEPARTMENT AS A MEDICAL ASSISTANCE SITE AND DETERMINES THAT THE  
11 PATIENT IS PRESUMPTIVELY ELIGIBLE FOR MEDICAL ASSISTANCE, INFORM  
12 THE PATIENT OF THE DETERMINATION AND PROVIDE THE PATIENT WITH  
13 INFORMATION ON HOW THE PATIENT CAN ENROLL IN PUBLIC HEALTH-CARE  
14 COVERAGE;

15 (d) IF THE HEALTH-CARE FACILITY DETERMINES THAT A PATIENT  
16 IS LIKELY ELIGIBLE FOR PUBLIC HEALTH-CARE COVERAGE INFORM THE  
17 PATIENT OF THE DETERMINATION AND:

18 (I) PROVIDE THE PATIENT WITH INFORMATION EXPLAINING HOW TO  
19 APPLY FOR PUBLIC HEALTH-CARE COVERAGE, INCLUDING AT LEAST ONE  
20 AVAILABLE METHOD FOR SUBMITTING AN APPLICATION;

21 (II) OFFER REASONABLE ASSISTANCE OR REFERRAL FOR SUPPORT  
22 TO COMPLETE AN APPLICATION FOR PUBLIC-HEALTH CARE COVERAGE; AND

23 (III) TREAT COMPLETION OF AN APPLICATION FOR PUBLIC  
24 HEALTH-CARE COVERAGE AS THE PRIMARY PATHWAY FOR RESOLVING THE  
25 PATIENT'S FINANCIAL RESPONSIBILITY FOR HOSPITAL SERVICES UNTIL THE  
26 PATIENT IS DENIED PUBLIC HEALTH-CARE COVERAGE OR 45 DAYS AFTER  
27 THE DATE OF DISCHARGE, WHICHEVER OCCURS FIRST; AND

1           (e) IF THE HEALTH-CARE FACILITY NEEDS MORE INFORMATION TO  
2           MAKE A DETERMINATION OF WHETHER THE PATIENT HAS QUALIFIED OR IS  
3           LIKELY TO QUALIFY FOR DISCOUNTED CARE OR A FINANCIAL ASSISTANCE  
4           PROGRAM, NOTIFY THE PATIENT THAT THE PATIENT MUST PROVIDE  
5           ADDITIONAL INFORMATION TO COMPLETE AN APPLICATION PURSUANT TO  
6           SECTION 25.5-3-502.5.

7           (3.7) (a) IF A PATIENT HAS NOT BEEN DETERMINED ELIGIBLE FOR  
8           PUBLIC HEALTH-CARE COVERAGE PURSUANT TO SUBSECTION (3.5)(d) OF  
9           THIS SECTION WITHIN 45 DAYS AFTER THE DATE OF DISCHARGE, A  
10          HEALTH-CARE FACILITY SHALL PROCEED WITH A DETERMINATION OF  
11          WHETHER THE PATIENT IS A QUALIFIED PATIENT.

12          (b) SUBSECTION (3.5)(d) OF THIS SECTION DOES NOT PROHIBIT A  
13          PATIENT OR HEALTH-CARE FACILITY FROM COMPLETING AN APPLICATION  
14          PURSUANT TO SECTION 25.5-3-502.5 WHILE A DETERMINATION OF THE  
15          PATIENT'S ELIGIBILITY FOR PUBLIC HEALTH-CARE COVERAGE IS PENDING.

16          (c) WHILE A DETERMINATION OF A PATIENT'S ELIGIBILITY FOR  
17          PUBLIC HEALTH-CARE COVERAGE IS PENDING, A HEALTH-CARE FACILITY  
18          MAY DEFER COMPLETION OF A FINAL DETERMINATION FOR DISCOUNTED  
19          CARE IF THE PATIENT IS AFFORDED THE PROTECTIONS FROM BILLING AND  
20          COLLECTION ACTIVITY REQUIRED BY SECTION 25.5-3-506.

21          (d) A HEALTH-CARE FACILITY SHALL NOT DENY ELIGIBILITY FOR  
22          DISCOUNTED CARE SOLELY BECAUSE A PATIENT DID NOT APPLY FOR PUBLIC  
23          HEALTH-CARE COVERAGE.

24          (4) If the patient declines the screening described in subsection (1)  
25          of this section, the health-care facility shall document the patient's  
26          decision in accordance with state department rules. A patient's decision  
27          to decline the screening that is documented and complies with state

1 department rules is a complete defense to a claim brought by a patient  
2 under section 25.5-3-506 (2) for a violation of section 25.5-3-506 (1)(a)  
3 or (1)(b).

4 (5) If requested by the AN INSURED patient, a health-care facility  
5 shall screen an insured patient for discounted care pursuant to subsections  
6 (1)(b) and (1)(c) of this section PERFORM THE SCREENING DESCRIBED IN  
7 THIS SECTION AND, IF APPLICABLE, COMPLETE THE APPLICATION PURSUANT  
8 TO SECTION 25.5-3-502.5 TO DETERMINE IF THE INSURED PATIENT IS A  
9 QUALIFIED PATIENT.

10 (6) AS USED IN THIS SECTION, "INFORM" MEANS TO CONVEY  
11 REQUIRED INFORMATION, UNLESS OTHERWISE SPECIFIED IN THIS SECTION,  
12 INCLUDING THROUGH VERBAL, ELECTRONIC, OR OTHER FORMATS. THE  
13 HEALTH-CARE FACILITY SHALL DOCUMENT THE MANNER IN WHICH THE  
14 INFORMATION WAS PROVIDED.

15 (7) A HEALTH-CARE FACILITY MAY USE THE SAME  
16 COMMUNICATION TO COMPLY WITH BOTH STATE AND FEDERAL  
17 REQUIREMENTS.

18 **SECTION 8.** In Colorado Revised Statutes, add 25.5-3-502.5 as  
19 follows:

20 **25.5-3-502.5. Uniform application for discounted care.**

21 (1) AFTER COMPLETION OF THE SCREENING CONDUCTED PURSUANT  
22 TO SECTION 25.5-3-502, A HEALTH-CARE FACILITY SHALL REQUEST  
23 INFORMATION FROM A PATIENT TO COMPLETE A UNIFORM APPLICATION  
24 FOR DISCOUNTED CARE IF:

25 (a) THE HEALTH-CARE FACILITY NEEDS MORE INFORMATION TO  
26 MAKE A DETERMINATION OF WHETHER THE PATIENT HAS QUALIFIED OR IS  
27 LIKELY TO QUALIFY FOR DISCOUNTED CARE OR THE HEALTH-CARE

1 FACILITY'S FINANCIAL ASSISTANCE PROGRAM, INCLUDING IF THE  
2 HEALTH-CARE FACILITY'S POLICY IS TO REQUIRE AN APPLICATION PRIOR TO  
3 MAKING A FINAL DETERMINATION; OR

4 (b) THE PATIENT REQUESTS AN APPLICATION, UNLESS THE PATIENT  
5 HAS NO BALANCE REMAINING AFTER APPLYING ANY DISCOUNTS PURSUANT  
6 TO SECTION 25.5-3-503 OR THE HEALTH-CARE FACILITY'S FINANCIAL  
7 ASSISTANCE PROGRAM.

8 (2) A HEALTH-CARE FACILITY SHALL USE THE UNIFORM  
9 APPLICATION DEVELOPED BY THE STATE DEPARTMENT TO COMPLETE THE  
10 APPLICATION REQUIRED BY THIS SECTION.

11 (3) UPON COMPLETION AND REVIEW OF THE APPLICATION, A  
12 HEALTH-CARE FACILITY SHALL:

13 (a) IF THE HEALTH-CARE FACILITY DETERMINES THAT A PATIENT  
14 IS A QUALIFIED PATIENT, PROVIDE THE PATIENT NOTICE OF THE  
15 DETERMINATION, THE PATIENT'S IDENTIFIED FEDERAL POVERTY GUIDELINE  
16 PERCENTAGE, AND THE PATIENT'S MONTHLY INSTALLMENT MAXIMUM  
17 PAYMENT AS DESCRIBED IN SECTION 25.5-3-503;

18 (b) IF THE HEALTH-CARE FACILITY DETERMINES THAT A PATIENT  
19 IS NOT A QUALIFIED PATIENT, PROVIDE THE PATIENT NOTICE OF THE  
20 DETERMINATION, WHICH, IF APPLICABLE, MAY ALSO INCLUDE NOTICE THAT  
21 THE PATIENT IS ELIGIBLE FOR THE HEALTH-CARE FACILITY'S FINANCIAL  
22 ASSISTANCE PROGRAM AND THE AMOUNT OF ANY DISCOUNT OFFERED  
23 THROUGH THAT PROGRAM, AND SHALL PROVIDE EITHER:

24 (I) AN OPPORTUNITY FOR THE PATIENT TO APPEAL THE  
25 DETERMINATION IN ACCORDANCE WITH STATE DEPARTMENT RULES; OR

26 (II) A STATEMENT THAT THE PATIENT HAS NO BALANCE DUE AFTER  
27 APPLYING ANY DISCOUNTS FROM THE HEALTH-CARE FACILITY'S FINANCIAL

1 ASSISTANCE PROGRAM; AND

2 (c) IF THE HEALTH-CARE FACILITY IS CERTIFIED BY THE STATE  
3 DEPARTMENT AS A MEDICAL ASSISTANCE SITE AND DETERMINES THAT THE  
4 PATIENT IS PRESUMPTIVELY ELIGIBLE FOR MEDICAL ASSISTANCE, PROVIDE  
5 THE PATIENT NOTICE OF THE DETERMINATION AND INFORMATION ON HOW  
6 THE PATIENT CAN ENROLL IN PUBLIC HEALTH-CARE COVERAGE.

7 **SECTION 9.** In Colorado Revised Statutes, 25.5-3-503, amend  
8 (1) introductory portion and (2)(a) as follows:

9 **25.5-3-503. Health-care discounts on services not eligible for**  
10 **Colorado indigent care program reimbursement - definition.**

11 (1) Beginning September 1, 2022, if a patient is screened pursuant  
12 to section 25.5-3-502 OR HAS COMPLETED A UNIFORM APPLICATION  
13 PURSUANT TO SECTION 25.5-3-502.5 and is determined to be a qualified  
14 patient, a health-care facility and a licensed health-care professional shall,  
15 for emergency hospital and other health-care services:

16 (2) A health-care facility shall not:

17 (a) Deny discounted care on the basis that the patient has not  
18 applied for any public benefits program, unless during the initial  
19 screening the patient is determined to be presumptively eligible for the  
20 state medical assistance program; or

21 **SECTION 10.** In Colorado Revised Statutes, 25.5-3-504, amend  
22 (1) introductory portion; and add (2) as follows:

23 **25.5-3-504. Notification of patients' rights - website link.**

24 (1) ~~Beginning September 1, 2022,~~ A health-care facility shall  
25 make information developed by the state department about patients' rights  
26 under this part 5 and ~~the uniform application~~ A LINK ON THE STATE  
27 DEPARTMENT WEBSITE TO ACCESS THE UNIFORM APPLICATION developed

1 by the state department pursuant to section 25.5-3-505 (2)(i) available to  
2 the public and to each patient. At a minimum, the health-care facility  
3 shall:

4 (2) THE STATE DEPARTMENT SHALL POST THE UNIFORM  
5 APPLICATION DEVELOPED PURSUANT TO SECTION 25.5-3-505 (2)(i) IN ALL  
6 REQUIRED LANGUAGES ON A PUBLICLY ACCESSIBLE WEBSITE.

7 **SECTION 11.** In Colorado Revised Statutes, 25.5-3-505, amend  
8 (2) introductory portion, (2)(c)(II), (2)(d), (2)(e), (2)(f), (2)(g), (2)(i), (5)  
9 introductory portion, (5)(b)(I), and (5)(b)(II); and add (2)(d.5) and (7) as  
10 follows:

11 **25.5-3-505. Health-care facility reporting requirements -**  
12 **agency enforcement - report - rules.**

13 (2) No later than ~~April 1, 2022~~ JULY 1, 2027, the state board shall  
14 promulgate ADOPT rules necessary for the administration and  
15 implementation of this part 5. At a minimum, the rules must:

16 (c) Establish the process for and the maximum number of days  
17 that a health-care facility has to:

18 (II) Request information from ~~the~~ A patient needed for the  
19 screening process IF THE HEALTH-CARE FACILITY CONDUCTS A SCREENING  
20 USING THE UNIFORM SCREENING QUESTIONNAIRE AS DESCRIBED IN  
21 SECTION 25.5-3-502 (2); and

22 (d) Outline the requirements for notifying the patient of the results  
23 of the screening, including:

24 (I) An explanation of the basis for a denial of discounted care; and

25 (II) The process for ~~appealing a denial~~ COMPLETING AN  
26 APPLICATION TO PROVIDE MORE INFORMATION TO DETERMINE WHETHER  
27 THE PATIENT IS A QUALIFIED PATIENT;

1           (d.5) ESTABLISH A PROCESS FOR AND THE MAXIMUM NUMBER OF  
2 DAYS THAT A HEALTH-CARE FACILITY HAS TO:

3           (I) REQUEST INFORMATION FROM THE PATIENT TO COMPLETE AN  
4 APPLICATION, IF THE APPLICATION IS REQUIRED PURSUANT TO SECTION  
5 25.5-3-502.5; AND

6           (II) COMPLETE THE APPLICATION PROCESS AS DESCRIBED IN  
7 SECTION 25.5-3-502.5;

8           (e) Establish guidelines for patient appeals regarding eligibility for  
9 discounted care pursuant to section 25.5-3-503 25.5-3-502.5;

10           (f) Establish a methodology that all ACCEPTABLE METHODOLOGIES  
11 FOR health-care facilities must use to determine monthly household  
12 income. FOR PURPOSES OF THE SCREENING CONDUCTED PURSUANT TO  
13 SECTION 25.5-3-502, THE USE OF AN INDUSTRY-STANDARD THIRD-PARTY  
14 RESOURCE, INCLUDING MAJOR CREDIT BUREAUS, IS AN ACCEPTABLE  
15 METHODOLOGY. The methodology METHODOLOGIES must not consider a  
16 patient's assets.

17           (g) FOR PURPOSES OF THE APPLICATION, identify the documents  
18 that may be required to establish income eligibility for discounted care  
19 using the minimum amount of information needed to determine  
20 eligibility;

21           (i) Create a uniform application that a health-care facility must use  
22 when AN APPLICATION IS REQUIRED AFTER screening a patient for  
23 eligibility for discounted care, as described in section 25.5-3-502  
24 SECTIONS 25.5-3-502 AND 25.5-3-502.5; AND

25           (5) No later than April 1, 2022, The state department: shall:

26           (b) (I) SHALL establish a process for patients to submit a  
27 complaint relating to noncompliance with this part 5 to the state

1 department by phone, BY mail, or online. The state department shall  
2 conduct a review OF A PATIENT'S COMPLAINT within thirty days after  
3 receiving a THE complaint.

4 (II) (A) The state department Shall periodically review health-care  
5 facilities and licensed health-care professionals to ensure compliance with  
6 this section QUALIFIED PATIENTS ARE IDENTIFIED IN COMPLIANCE WITH  
7 THIS PART 5 AND ARE NOT CHARGED MORE THAN THE DISCOUNTED RATE  
8 ESTABLISHED IN STATE BOARD RULES PURSUANT TO SUBSECTION (2)(j) OF  
9 THIS SECTION. THE REVIEW SHALL BE CONDUCTED IN ACCORDANCE WITH  
10 STATE DEPARTMENT RULES, AND THE FREQUENCY, SAMPLE SIZE, AND  
11 TIMELINE OF THE REVIEW MUST BE REASONABLE CONSIDERING THE SIZE  
12 AND RESOURCES OF THE HEALTH-CARE FACILITY.

13 (B) If the state department finds that a health-care facility or  
14 licensed health-care professional is not in compliance with this section,  
15 AND THE NONCOMPLIANCE HAS RESULTED IN A DELAY OR DENIAL OF A  
16 DISCOUNT OWED TO A PATIENT AS A RESULT OF THE SCREENING REQUIRED  
17 PURSUANT TO SECTION 25.5-3-502, the state department shall notify the  
18 health-care facility or licensed health-care professional and the facility or  
19 professional has ninety days AFTER NOTIFICATION to file a corrective  
20 action plan with the state department. that IF THE NONCOMPLIANCE  
21 RESULTED IN EXCESS CHARGES TO THE PATIENT, THE CORRECTIVE ACTION  
22 PLAN must include measures to inform the patient about the  
23 noncompliance and provide a financial correction consistent with this part  
24 5. A health-care facility or licensed health-care professional may request  
25 up to one hundred twenty days to submit a corrective action plan. The  
26 state department may require a health-care facility or licensed health-care  
27 professional that is not in compliance with this part 5 or any state board

1 rules adopted pursuant to this part 5 to develop and operate under a  
2 corrective action plan until the state department determines the  
3 health-care facility or licensed health-care professional is in compliance.

4 (C) IF A HEALTH-CARE FACILITY'S OR LICENSED HEALTH-CARE  
5 PROFESSIONAL'S NONCOMPLIANCE WITH THIS PART 5 DID NOT RESULT IN A  
6 DELAY OR DENIAL OF A DISCOUNT OWED TO A PATIENT AS A RESULT OF THE  
7 SCREENING REQUIRED PURSUANT TO SECTION 25.5-3-502, THE STATE  
8 DEPARTMENT MAY NOTIFY THE HEALTH-CARE FACILITY OR LICENSED  
9 HEALTH-CARE PROFESSIONAL OF THE NONCOMPLIANCE FOR PURPOSES OF  
10 QUALITY IMPROVEMENT.

11 (7) (a) THE STATE DEPARTMENT OR THE STATE BOARD SHALL NOT  
12 IMPOSE CHANGES TO THE UNIFORM SCREENING QUESTIONNAIRE, CHANGES  
13 TO THE APPLICATION, NEW REQUIREMENTS, NEW REPORTING OBLIGATIONS,  
14 NEW DOCUMENTATION STANDARDS, NEW DATA ELEMENTS, OR NEW  
15 PROGRAM CRITERIA THROUGH MANUALS, POLICY, OR OTHER  
16 SUBREGULATORY ISSUANCES UNLESS THE CHANGES OR NEW  
17 REQUIREMENTS HAVE BEEN:

18 (I) ADOPTED BY RULE PURSUANT TO THE "STATE ADMINISTRATIVE  
19 PROCEDURE ACT", ARTICLE 4 OF TITLE 24, BY SEPTEMBER 1, 2026, FOR A  
20 RULE THAT WILL GO INTO EFFECT DURING TO THE 2026-27 STATE FISCAL  
21 YEAR AND EVERY YEAR THEREAFTER BY JUNE 1 PRIOR TO THE STATE  
22 FISCAL YEAR FOR WHICH THE RULE WILL GO INTO EFFECT; AND

23 (II) SUBJECT TO STAKEHOLDER ENGAGEMENT PURSUANT TO  
24 SUBSECTION (4) OF THIS SECTION.

25 (b) ANY CHANGE OR NEW REQUIREMENT DESCRIBED IN  
26 SUBSECTION (7)(a) OF THIS SECTION THAT WAS NOT ADOPTED THROUGH  
27 RULE-MAKING IS ADVISORY ONLY AND DOES NOT SERVE AS THE BASIS FOR

1 ENFORCEMENT.

2 (c) THE STATE DEPARTMENT SHALL MAINTAIN AN UPDATED PUBLIC  
3 ARCHIVE OF ALL MANUALS AND SUBREGULATORY ISSUANCES, INCLUDING  
4 THE RATIONALE FOR CHANGES AND CITATIONS TO STATUTORY OR  
5 REGULATORY AUTHORITY FOR EACH CHANGE OR NEW REQUIREMENT.

6 (d) THIS SUBSECTION (7) DOES NOT APPLY TO RULES ADOPTED BY  
7 THE STATE DEPARTMENT OR THE STATE BOARD TO UPDATE ANNUAL  
8 FEDERAL POVERTY GUIDELINES OR IN RESPONSE TO EMERGENT AND  
9 IMMEDIATE TRENDS THAT ARE IDENTIFIED BY CONSUMERS OR HOSPITALS  
10 AS LIMITING THE PROGRAM'S EFFECTIVENESS AND ARE DEMONSTRATED BY  
11 DATA SUBMITTED TO THE STATE DEPARTMENT OR THE STATE BOARD.

12 SECTION 12. In Colorado Revised Statutes, 25.5-4-402.8,  
13 amend (2)(b) introductory portion, (2)(b)(II)(A), and (2)(e) as follows:

14 25.5-4-402.8. Hospital transparency report and requirements  
15 - definitions - rules.

16 (2) (b) Except as provided in subsection (2)(c) of this section,  
17 each hospital licensed pursuant to part 1 of article 3 of title 25, or certified  
18 pursuant to section 25-1.5-103 (1)(a)(II), shall make information available  
19 to the state department for purposes of preparing the annual hospital  
20 transparency report. The state board shall establish the CONTENT AND  
21 format of the information provided by each hospital on an annual basis BY  
22 RULE, ESTABLISHING THE FORMAT FOR INFORMATION FOR THE 2026  
23 ANNUAL REPORT AS THE DEFAULT FORMAT UNLESS MODIFIED BY RULE.  
24 Each hospital shall provide the following information to the state  
25 department ON AN ANNUAL BASIS USING THE MOST RECENT CONTENT AND  
26 FORMAT REQUIREMENTS THAT WERE ADOPTED BY THE STATE BOARD AT  
27 LEAST THIRTY DAYS PRIOR TO THE BEGINNING OF THE HOSPITAL'S FISCAL

1 YEAR:

2 (II) (A) Annual audited financial statements, prepared in  
3 accordance with generally accepted accounting principles. Each hospital  
4 shall submit the statements within one hundred ~~twenty~~ FIFTY days after  
5 the end of its fiscal year unless the state department grants an extension  
6 in writing in advance of that date.

7 (e) Prior to issuing the hospital transparency report, the state  
8 department shall provide any hospital referenced in the hospital  
9 transparency report a copy of the DRAFT report BY DECEMBER 1 OF EACH  
10 YEAR. Each hospital AND A STATEWIDE HOSPITAL ASSOCIATION must have  
11 a minimum of fifteen BUSINESS days to review the hospital transparency  
12 report and any underlying data and submit corrections or clarifications to  
13 the state department.

14 **SECTION 13.** In Colorado Revised Statutes, 6-20-203, amend  
15 (5)(b) and (5)(c) as follows:

16 **6-20-203. Limitations on collection actions - definition.**

17 (5) Beginning September 1, 2022, a medical creditor collecting on  
18 a debt for hospital services shall not sell a medical debt to another party  
19 unless, prior to the sale, the medical debt seller has entered into a legally  
20 binding written agreement with the medical debt buyer of the debt  
21 pursuant to which:

22 (b) The debt is returnable to or recallable by the medical debt  
23 seller upon a determination that the patient should have been screened  
24 pursuant to ~~section 25.5-3-502~~ SECTIONS 25.5-3-502 AND 25.5-3-502.5  
25 and is eligible for discounted care pursuant to section 25.5-3-503 or that  
26 the bill underlying the medical debt is eligible for reimbursement through  
27 a public health-care coverage program; and

1           (c) If it is determined that the patient should have been screened  
2 pursuant to ~~section 25.5-3-502~~ SECTIONS 25.5-3-502 AND 25.5-3-502.5  
3 and is eligible for discounted care pursuant to section 25.5-3-503 or that  
4 the bill underlying the medical debt is eligible for reimbursement through  
5 a public health-care coverage program and the debt is not returned to or  
6 recalled by the medical debt seller, the medical debt buyer shall adhere to  
7 procedures that must be specified in the agreement that ensures the  
8 patient will not pay, and has no obligation to pay, the medical debt buyer  
9 and the medical creditor together more than the patient is personally  
10 responsible for paying.

11           **SECTION 14.** In Colorado Revised Statutes, 12-220-306, **amend**  
12 (4) as follows:

13           **12-220-306. Dentists may prescribe drugs - surgical operations**  
14 **- anesthesia - limits on prescriptions - rules.**

15           (4) A licensed dentist is strongly encouraged to purchase or utilize  
16 an electronic health product that includes integration of a tool that  
17 facilitates dentists' compliance with prescription drug monitoring  
18 standards. required by section 12-30-114 (1)(a)(IV).

19           **SECTION 15.** In Colorado Revised Statutes, 12-240-130, **amend**  
20 (2)(a)(II); and **repeal** (2)(a)(III) and (5) as follows:

21           **12-240-130. Renewal, reinstatement, reactivation -**  
22 **delinquency - fees - questionnaire.**

23           (2) (a) The board shall design a questionnaire to accompany the  
24 renewal form for the purpose of determining whether a licensee has acted  
25 in violation of this article 240 or has been disciplined for any action that  
26 might be considered a violation of this article 240 or that might make the  
27 licensee unfit to practice medicine with reasonable care and safety. The

1 board shall include on the questionnaire a question regarding whether:  
2 (II) The licensee is in compliance with section 12-280-403 (2)(a)  
3 and is aware of the penalties for failing to comply with that section; AND  
4 (III) The licensee is in compliance with section 12-30-114; and  
5 (5) On and after October 1, 2022, as a condition of renewal,  
6 reinstatement, or reactivation of a license, each licensee or applicant shall  
7 attest that the licensee or applicant is in compliance with section  
8 12-30-114 and that the licensee or applicant is aware of the penalties for  
9 noncompliance with that section.

10 SECTION 16. In Colorado Revised Statutes, 12-240-130.5,  
11 amend (6) as follows:

12 12-240-130.5. Continuing medical education - requirement -  
13 compliance - legislative declaration - rules - definitions.

14 (6) As part of the CME requirement established pursuant to this  
15 section, in addition to CME programs covering topics selected by the  
16 physician, a physician's CME credit hours must include

17 (a) CME credit hours that comply with section 12-30-114 and  
18 related board rules; and

19 (b) CME credit hours covering a topic specified by the board by  
20 rule pursuant to subsection (7)(b) of this section.

21 SECTION 17. In Colorado Revised Statutes, 25-1.5-103, amend  
22 (1)(a)(I)(A) and (1)(a)(I)(F) as follows:

23 25-1.5-103. Health facilities - powers and duties of department  
24 - rules - limitations on rules - definitions - repeal.

25 (1) The department has, in addition to all other powers and duties  
26 imposed upon it by law, the powers and duties provided in this section as  
27 follows:

1           (a) (I) (A) To annually license and to establish and enforce  
2           standards for the operation of general hospitals, hospital units as defined  
3           in section 25-3-101 (2)(b), freestanding emergency departments as  
4           defined in section 25-1.5-114 (5)(b)(I), critical access hospitals as defined  
5           in section 25-1.5-114.5 (1)(b), psychiatric hospitals, community clinics,  
6           rehabilitation hospitals, convalescent centers, facilities for persons with  
7           intellectual and developmental disabilities, nursing care facilities, hospice  
8           care, assisted living residences, dialysis treatment clinics, ambulatory  
9           surgical centers, birthing centers, home care agencies, and other facilities  
10           of a like nature, except those wholly owned and operated by a  
11           governmental unit or agency.

12           (F) Sections 24-4-104 C.R.S., and 25-3-102 govern the issuance,  
13           suspension, renewal, revocation, annulment, or modification of licenses.  
14           All licenses issued by the department must contain the date of issue, and  
15           cover a twelve-month period. Nothing contained in this paragraph (a)  
16           SUBSECTION (1)(a) prevents the department from adopting and enforcing,  
17           with respect to projects for which federal assistance has been obtained or  
18           is requested, higher standards as may be required by applicable federal  
19           laws or regulations of federal agencies responsible for the administration  
20           of applicable federal laws.

21           **SECTION 18. Act subject to petition - effective date.** Section  
22           25-3-102, Colorado Revised Statutes, as amended in section 4 of this act,  
23           and section 25-1.5-103, Colorado Revised Statutes, as amended in section  
24           16 of this act, take effect July 1, 2028, and the remainder of this act takes  
25           effect at 12:01 a.m. on the day following the expiration of the ninety-day  
26           period after final adjournment of the general assembly; except that, if a  
27           referendum petition is filed pursuant to section 1 (3) of article V of the

1 state constitution against this act or an item, section, or part of this act  
2 within such period, then the act, item, section, or part will not take effect  
3 unless approved by the people at the general election to be held in  
4 November 2026 and, in such case, will take effect on the date of the  
5 official declaration of the vote thereon by the governor; except that  
6 section 25-3-102, Colorado Revised Statutes, as amended in section 4 of  
7 this act, and section 25-1.5-103, Colorado Revised Statutes, as amended  
8 in section 16 of this act, take effect July 1, 2028.