Second Regular Session
Seventy-fifth General Assembly
STATE OF COLORADO

REREVISED
This Version Includes All Amendments
Adopted in the Second House

LLS NO. 26-0721.01 Josh Schultz x5486 **SENATE BILL 26-138**

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May 6, 2026

SENATE
3rd Reading Unamended
May 1, 2026

SENATE
Amended 2nd Reading
April 30, 2026

A BILL FOR AN ACT

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

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.

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.

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

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

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

(b) It is the intent of the general assembly to reduce unnecessary paperwork, eliminate avoidable burdens, and create a process that respects people's time, circumstances, and dignity. Streamlining and

clarifying these pathways will allow health-care providers to focus more resources on helping families instead of on navigating shifting rules or administrative obstacles.

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

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

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

12-30-114. Demonstrated competency - repeal of rules - repeal.

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

~~(I) Best practices for opioid prescribing, according to the most recent version of the division's guidelines for the safe prescribing and dispensing of opioids;~~

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

~~(III) Best practices for prescribing benzodiazepines;~~

~~(IV) Recognition of substance use disorders;~~

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

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

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

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

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

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

~~(a) A physician;~~

~~(b) A physician assistant;~~

~~(c) A podiatrist;~~

~~(d) A dentist;~~

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

~~(f) An optometrist; and~~

~~(g) A veterinarian.~~

(3) EACH REGULATOR THAT ADOPTED RULES PURSUANT TO THIS SECTION BEFORE THE EFFECTIVE DATE OF THIS SUBSECTION (3), WHICH RULES REQUIRE A LICENSED HEALTH-CARE PROVIDER, AS A CONDITION OF RENEWING, REACTIVATING, OR REINSTATING A LICENSE, TO COMPLETE UP TO FOUR CREDIT HOURS OF TRAINING PER LICENSING CYCLE IN ORDER TO

DEMONSTRATE OPIATE PRESCRIBER COMPETENCY SHALL REPEAL THE RULES ON OR BEFORE JULY 1, 2027.

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

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

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

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

(I) BEST PRACTICES FOR OPIOID PRESCRIBING;

(II) BEST PRACTICES FOR BENZODIAZEPINE PRESCRIBING;

(III) RECOGNITION OF SUBSTANCE USE DISORDERS;

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

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

(b) REGARDLESS OF WHETHER THE BOARD ADOPTS RULES TO REQUIRE TRAINING PURSUANT TO SUBSECTION (3)(a) OF THIS SECTION, IF A LICENSED DENTIST, DENTAL THERAPIST, OR DENTAL HYGIENIST COMPLETES TRAINING REGARDING OPIOID PRESCRIBER COMPETENCY, THE BOARD SHALL COUNT UP TO FOUR HOURS OF SUCH TRAINING TOWARD THE LICENSEE'S CONTINUING EDUCATION REQUIRED BY SUBSECTION (1) OF THIS SECTION.

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

12-315-110. License renewal - waiver - rules - continuing education.

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

(I) BEST PRACTICES FOR VETERINARY OPIOID PRESCRIBING;

(II) BEST PRACTICES FOR VETERINARY BENZODIAZEPINE PRESCRIBING;

(III) RECOGNITION OF HUMAN SUBSTANCE USE DISORDERS;

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

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

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

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

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

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

SECTION 5. In Colorado Revised Statutes, 25-3-102, **amend** (1)(a); and **repeal** (1)(d) as follows:

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

(1) (a) (I) An applicant for a license described in section 25-3-101 shall apply to the department ~~of public health and environment annually~~

EVERY TWO YEARS upon such form and in such manner as prescribed by the department; except that a community residential home shall make application for a license pursuant to section 25.5-10-214. ~~C.R.S.~~

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

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

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

25.5-3-501. Definitions.

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

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

(6.7) "UNIFORM APPLICATION" OR "APPLICATION" MEANS A UNIFORM FORM THAT IS DEVELOPED BY THE STATE DEPARTMENT TO DETERMINE WHETHER A PATIENT IS A QUALIFIED PATIENT AND IS

COMPLETED FOLLOWING A SCREENING OR WHEN REQUIRED BY SECTION 25.5-3-502.5.

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

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

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

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

~~(b) Repealed.~~

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

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

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

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

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

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

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

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

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

(b) IF THE HEALTH-CARE FACILITY DETERMINES THAT A PATIENT IS LIKELY NOT A QUALIFIED PATIENT, INFORM THE PATIENT OF THE RESULTS OF THE SCREENING, INCLUDING THE PATIENT'S IDENTIFIED FEDERAL POVERTY GUIDELINE PERCENTAGE, AND PROVIDE THE PATIENT WITH:

(I) INFORMATION ON HOW TO COMPLETE AN APPLICATION

PURSUANT TO SECTION 25.5-3-502.5; AND

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

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

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

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

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

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

(e) IF THE HEALTH-CARE FACILITY NEEDS MORE INFORMATION TO MAKE A DETERMINATION OF WHETHER THE PATIENT HAS QUALIFIED OR IS LIKELY TO QUALIFY FOR DISCOUNTED CARE OR A FINANCIAL ASSISTANCE

PROGRAM, INFORM THE PATIENT OF THE PATIENT'S IDENTIFIED FEDERAL POVERTY GUIDELINE PERCENTAGE AND NOTIFY THE PATIENT THAT THE PATIENT MUST PROVIDE ADDITIONAL INFORMATION TO COMPLETE AN APPLICATION PURSUANT TO SECTION 25.5-3-502.5.

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

(II) UPON NOTIFICATION OF A DETERMINATION THAT A PATIENT IS INELIGIBLE FOR PUBLIC HEALTH-CARE COVERAGE PURSUANT TO SUBSECTION (3.5)(d) OF THIS SECTION, A HEALTH-CARE FACILITY SHALL PROCEED WITH A DETERMINATION OF WHETHER THE PATIENT IS A QUALIFIED PATIENT.

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

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

(d) IF A PATIENT IS DETERMINED ELIGIBLE FOR PUBLIC HEALTH-CARE COVERAGE PURSUANT TO SUBSECTION (3.5)(d) OF THIS SECTION, REIMBURSEMENT THROUGH PUBLIC HEALTH-CARE COVERAGE IS THE PRIMARY REIMBURSEMENT BEFORE ANY DISCOUNTS ARE PROVIDED

PURSUANT TO THIS SECTION.

(e) WHERE A HEALTH-CARE FACILITY DETERMINES, BASED ON AVAILABLE INFORMATION, THAT A PATIENT IS FACIALLY INELIGIBLE FOR PUBLIC HEALTH-CARE COVERAGE, THE HEALTH-CARE FACILITY MAY PROCEED DIRECTLY WITH A DETERMINATION OF WHETHER THE PATIENT IS A QUALIFIED PATIENT.

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

(4) If the patient declines the screening described in ~~subsection (1) of~~ this section, the health-care facility shall document the patient's decision in accordance with state department rules. A patient's decision to decline the screening that is documented and complies with state department rules is a complete defense to a claim brought by a patient under section 25.5-3-506 (2) for a violation of section 25.5-3-506 (1)(a) or (1)(b).

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

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

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

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

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

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

(a) THE HEALTH-CARE FACILITY NEEDS MORE INFORMATION TO MAKE A DETERMINATION OF WHETHER THE PATIENT HAS QUALIFIED OR IS LIKELY TO QUALIFY FOR DISCOUNTED CARE OR THE HEALTH-CARE FACILITY'S FINANCIAL ASSISTANCE PROGRAM, INCLUDING IF THE HEALTH-CARE FACILITY'S POLICY IS TO REQUIRE AN APPLICATION PRIOR TO MAKING A FINAL DETERMINATION; OR

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

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

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

(a) IF THE HEALTH-CARE FACILITY DETERMINES THAT A PATIENT IS A QUALIFIED PATIENT, PROVIDE THE PATIENT NOTICE OF THE

DETERMINATION, THE PATIENT'S IDENTIFIED FEDERAL POVERTY GUIDELINE PERCENTAGE, AND THE PATIENT'S MONTHLY INSTALLMENT MAXIMUM PAYMENT AS DESCRIBED IN SECTION 25.5-3-503;

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

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

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

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

SECTION 9. In Colorado Revised Statutes, 25.5-3-503, **amend** (1) introductory portion and (2)(a) 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 OR HAS COMPLETED A UNIFORM APPLICATION PURSUANT TO SECTION 25.5-3-502.5 and is determined to be a qualified patient, a health-care facility and a licensed health-care professional shall,

for emergency hospital and other health-care services:

(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

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

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

(1) ~~Beginning September 1, 2022,~~ A health-care facility shall make information developed by the state department about patients' rights under this part 5 and ~~the uniform application~~ A LINK ON THE STATE DEPARTMENT WEBSITE TO ACCESS THE UNIFORM APPLICATION developed by the state department pursuant to section 25.5-3-505 (2)(i) available to the public and to each patient. At a minimum, the health-care facility shall:

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

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

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

(2) No later than ~~April 1, 2022~~ JULY 1, 2027, the state board shall ~~promulgate~~ ADOPT rules necessary for the administration and

implementation of this part 5. At a minimum, the rules must:

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

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

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

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

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

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

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

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

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

(f) Establish ~~a methodology that all~~ ACCEPTABLE METHODOLOGIES FOR health-care facilities ~~must use~~ to determine monthly household income. FOR PURPOSES OF THE SCREENING CONDUCTED PURSUANT TO SECTION 25.5-3-502, THE USE OF AN INDUSTRY-STANDARD THIRD-PARTY RESOURCE, INCLUDING MAJOR CREDIT BUREAUS, IS AN ACCEPTABLE

METHODOLOGY. A HEALTH-CARE FACILITY SHALL DISCLOSE TO THE DEPARTMENT WHICH INDUSTRY-STANDARD THIRD-PARTY RESOURCES THEY USE TO DETERMINE MONTHLY HOUSEHOLD INCOME. The ~~methodology~~ METHODOLOGIES must not consider a patient's assets.

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

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

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

(b) (I) SHALL establish a process for patients to submit a complaint relating to noncompliance with this part 5 to the state department by phone, BY mail, or online. The state department shall conduct a review OF A PATIENT'S COMPLAINT within thirty days after receiving ~~a~~ THE complaint.

(II) (A) ~~The state department~~ Shall periodically review health-care facilities and licensed health-care professionals to ensure ~~compliance with this section~~ QUALIFIED PATIENTS ARE IDENTIFIED IN COMPLIANCE WITH THIS PART 5, ARE NOT CHARGED MORE THAN THE DISCOUNTED RATE ESTABLISHED IN STATE BOARD RULES PURSUANT TO SUBSECTION (2)(j) OF THIS SECTION, ARE OFFERED INSTALLMENT PAYMENTS AS REQUIRED BY SECTION 25.5-3-503, AND DO NOT HAVE THEIR DEBT ASSIGNED OR SOLD BEFORE ALL REQUIREMENTS OF SECTION 25.5-3-506 ARE MET. THE REVIEW SHALL BE CONDUCTED IN ACCORDANCE WITH STATE DEPARTMENT RULES,

AND THE FREQUENCY, SAMPLE SIZE, AND TIMELINE OF THE REVIEW MUST BE REASONABLE CONSIDERING THE SIZE AND RESOURCES OF THE HEALTH-CARE FACILITY.

(B) If the state department finds that a health-care facility or licensed health-care professional is not in compliance with this section, AND THE NONCOMPLIANCE HAS RESULTED IN A DELAY OR DENIAL OF A DISCOUNT OWED TO A PATIENT AS A RESULT OF THE SCREENING OR APPLICATION REQUIRED PURSUANT TO SECTION 25.5-3-502 OR 25.5-3-502.5, AS A RESULT OF THE HEALTH-CARE FACILITY OR THE LICENSED HEALTH-CARE PROFESSIONAL CHARGING THE PATIENT MORE THAN THE DISCOUNTED RATE ESTABLISHED IN STATE DEPARTMENT RULE PURSUANT TO SECTION 25.5-3-505 (2)(j), DUE TO A FAILURE TO OFFER INSTALLMENT PAYMENTS PURSUANT TO SECTION 25.5-3-503 OR DUE TO THE ASSIGNING OR SELLING OF PATIENT DEBT TO A COLLECTION AGENCY IN VIOLATION OF SECTION 25.5-3-506, the state department shall notify the health-care facility or licensed health-care professional and the facility or professional has ninety days AFTER NOTIFICATION to file a corrective action plan with the state department. ~~that~~ IF THE NONCOMPLIANCE RESULTED IN EXCESS CHARGES TO THE PATIENT, THE CORRECTIVE ACTION PLAN must include measures to inform the patient about the noncompliance and provide a financial correction consistent with this part 5. A health-care facility or licensed health-care professional may request up to one hundred twenty days to submit a corrective action plan. The state department may require a health-care facility or licensed health-care professional that is not in compliance with this part 5 or any state board rules adopted pursuant to this part 5 to develop and operate under a corrective action plan until the state department determines the

health-care facility or licensed health-care professional is in compliance.

(C) IF A HEALTH-CARE FACILITY'S OR LICENSED HEALTH-CARE PROFESSIONAL'S NONCOMPLIANCE WITH THIS PART 5 DID NOT RESULT IN A DELAY OR DENIAL OF A DISCOUNT OWED TO A PATIENT, THE STATE DEPARTMENT MAY NOTIFY THE HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE PROFESSIONAL OF THE NONCOMPLIANCE FOR PURPOSES OF QUALITY IMPROVEMENT.

(7) (a) THE STATE DEPARTMENT SHALL COMPLY WITH SECTION 24-4-103 (1) WHEN IMPOSING CHANGES TO THE UNIFORM SCREENING QUESTIONNAIRE, CHANGES TO THE APPLICATION, NEW REQUIREMENTS, NEW REPORTING OBLIGATIONS, NEW DOCUMENTATION STANDARDS, NEW DATA ELEMENTS, OR NEW PROGRAM CRITERIA. THE STATE DEPARTMENT SHALL ENSURE THE CHANGES OR NEW REQUIREMENTS ARE:

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

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

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

(c) THE STATE DEPARTMENT SHALL MAINTAIN AN UPDATED PUBLIC ARCHIVE OF ALL MANUALS AND SUBREGULATORY ISSUANCES, INCLUDING THE RATIONALE FOR CHANGES AND CITATIONS TO STATUTORY OR

REGULATORY AUTHORITY FOR EACH CHANGE OR NEW REQUIREMENT.

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

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

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

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

(II) (A) Annual audited financial statements, prepared in accordance with generally accepted accounting principles. Each hospital shall submit the statements within one hundred ~~twenty~~ FIFTY days after

the end of its fiscal year unless the state department grants an extension in writing in advance of that date.

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

SECTION 13. In Colorado Revised Statutes, 6-20-201, **amend** the introductory portion and (1) as follows:

6-20-201. Definitions.

~~For the purposes of~~ AS USED IN this part 2, unless the context otherwise requires:

(1) "Collection activity" means only those activities provided or performed by a licensed collection agency, using a business name other than the name of the health-care provider, for purposes of collecting a MEDICAL debt. The term does not include any standard billing procedures used by the health-care provider or its agent in the normal course of business on current, nondelinquent accounts.

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

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

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

pursuant to which:

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

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

SECTION 15. In Colorado Revised Statutes, 12-220-306, **amend** (4) as follows:

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

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

SECTION 16. In Colorado Revised Statutes, 12-240-130, **amend** (2)(a)(II); and **repeal** (2)(a)(III) and (5) as follows:

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

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

(II) The licensee is in compliance with section 12-280-403 (2)(a) and is aware of the penalties for failing to comply with that section; AND

(III) ~~The licensee is in compliance with section 12-30-114; and~~

(5) ~~On and after October 1, 2022, as a condition of renewal, reinstatement, or reactivation of a license, each licensee or applicant shall attest that the licensee or applicant is in compliance with section 12-30-114 and that the licensee or applicant is aware of the penalties for noncompliance with that section.~~

SECTION 17. In Colorado Revised Statutes, 12-240-130.5, **amend** (6) as follows:

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

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

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

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

SECTION 18. In Colorado Revised Statutes, 25-1.5-103, **amend** (1)(a)(I)(A) and (1)(a)(I)(F) as follows:

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

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

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

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

SECTION 19. Act subject to petition - effective date. Section 25-3-102, Colorado Revised Statutes, as amended in section 5 of this act, and section 25-1.5-103, Colorado Revised Statutes, as amended in section 18 of this act, take effect July 1, 2028, and the remainder of 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 2026 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor; except that section 25-3-102, Colorado Revised Statutes, as amended in section 5 of this act, and section 25-1.5-103, Colorado Revised Statutes, as amended in section 18 of this act, take effect July 1, 2028.