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Colorado Hospital Association

HB 23-1215 Guidance

Please note that this document is intended to serve as guidance based on the statutory language and legislative intent. It is not intended to be legal advice, and members should always check with their legal counsel.

REQUIREMENTS IN HOUSE BILL (HB) 23-1215 (EFFECTIVE JULY 1, 2024)

1. Health care provider or health system must not charge, bill, or collect a facility fee directly from a patient that is not covered by a patient's insurance for preventive health care services [C.R.S. 6-20-102(2)(a)].
    a. This requirement does not apply to Denver Health, Critical Access Hospitals, Sole-Community Hospitals in a rural or frontier area, or a community clinic affiliated with a sole community hospital in a rural or frontier area [C.R.S. 6-20-102 (4) & (5)].
2. Health care provider affiliated with or owned by a hospital or health system that charges a facility fee shall:
    a. Provide notice to patients that a facility fee may be charged and indicate the amount of the facility fee [C.R.S. 6-20-102(3)(a)((I)(A)].
        i. Notice must be provided at the time an appointment is scheduled and again at the time the services are rendered.
    b. Post a sign in English and Spanish near the check-in/registration desk that states a patient may be charged a facility fee [C.R.S. 6-20-102(3)(a)((I)(B)].
        i. The sign must include the location where a patient may inquire about facility fees and an online location where information about facility fees may be found.
    c. Provide patients with a standardized bill that includes itemized charges for each service, specifically identifies any facility fee, identifies specific charges that have been billed to insurance or other payer types, and includes contact information for filing an appeal with the provider to contest the charges [C.R.S. 6-20-102(3)(a)(II)].
        i. The bill must be provided and a clear manner and, to the extent practicable, in the patient's preferred language [C.R.S. 6-20-102(3)(b)].
3. A health facility newly affiliated with or owned by a hospital or health system on or after July 1, 2024, must provide written notice to each patient they have seen in the past twelve months noting the affiliation or change of ownership [C.R.S. 6-20-102(3)(c)(I)]. The notice must include:
    a. The name, business address, and phone number of the hospital or health system [C.R.S. 6-20-102(3)(c)(I)(A)];
    b. A statement that the health facility bills, or is likely to bill, patients a facility fee that may be in addition to or separate from any professional fee [C.R.S. 6-20-102(3)(c)(I)(B)];
    c. A statement that the patient should contact the patient's health insurer for additional information regarding the health facility's facility fee [C.R.S. 6-20-102(3)(c)(I)(C)].
    d. A hospital, health system, or health facility shall not collect a facility fee for services provided by a provider affiliated with or owned by a hospital/health system until at least thirty days after the written notice is mailed to the patient [C.R.S. 6-20-102(3)(c)(II)].

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IMPORTANT DEFINITIONS

Facility Fee: Any fee a hospital or health system charges or bills for outpatient hospital services that is:

- Intended to compensate the hospital/health system for its operational expenses [C.R.S. 6-20-102(1)(d)(I)]; and
- Separate and distinct from a professional fee charged or billed by a health care provider for professional medical services [C.R.S. 6-20-102(1)(d)(II)].

Affiliated with: Employed by a hospital or health system or under a professional services agreement, faculty agreement, or management agreement with a hospital or health system that permits the hospital or health system to bill on behalf of the affiliated entity [C.R.S. 6-20-102(1)(a)].

FREQUENTLY ASKED QUESTIONS

What services do these facility fee requirements apply to?

It is unclear exactly what constitutes a facility fee per the legislation. It could be interpreted broadly to apply to all outpatient services provided and billed by a provider affiliated with or owned by a hospital/health system, in which the patient is receiving a bill intended to compensate for operational expenses, and the bill is separate and distinct from a professional fee charge. It could also be interpreted more narrowly to only apply to outpatient services that have both a facility fee and professional fee, such that the patient is receiving two separate bills. CHA recommends that members connect with their own legal representation to determine your approach to what services this will cover.

- **Rationale**: The statute is unclear.

Transparency Requirements:

How should facility fees be separated on the itemized bill when we are providing bundled services or other charges that don't differentiate between professional and facility fees?

The legislation does not specify how to deal with bundled services or charges that are not 100 percent operational. CHA would recommend only counting those fees that are 100 percent operational as a facility fee. An itemized charge that includes a professional fee component to compensate a provider for professional medical services does not fall under the definition of a facility fee as it is not separate and distinct from a professional charge.

- **Rationale**: It would be impossible for a hospital to break down a charge by the operational components and other components. Therefore, since the statute defines a facility fee as intending to compensate a hospital for its operational expenses and as separate and distinct from a professional charge, only the fees that can clearly be defined as solely operational and do not have a professional fee component should be reported as a facility fee. Other fees separate from a facility fee or professional fee should be categorized as "other" or another appropriate title.

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How should the $ amount of the facility fee be provided to patients at time of scheduling and at time of service? In giving notice of a facility fee to patients, is a range sufficient? Facility fee amounts can vary based on the services rendered during the visit and based on the patient's insurance status.
The legislation does not specify how a $ amount should be provided to patients. CHA would recommend using either a range or average. The range/average should reflect what you can predict without filing the claim.

- **Rationale**: It would be impossible for a hospital to provide an accurate estimate of a facility fee prior to filing a claim. Therefore, a range/average will be more useful to the consumer.

Do we still have to follow the transparency requirements for preventive services provided in a hospital emergency department (ED) or freestanding ED?
The legislation does not explicitly address how the transparency requirements apply to EDs. CHA would recommend that EDs and freestanding EDs post a sign at their check-in area noting that a facility fee could be charged.

- **Rationale**: EDs and freestanding EDs do not schedule appointments in advance and do not have time during an emergency visit to provide an estimated facility fee charge.

How often do hospitals need to update posted transparency information?
A timeline is not specified in the legislation. CHA would recommend that any changes to the posted information (such as the online location where information about the facility fee may be found) should be reflected in the posted materials within 30 days of the change.

- **Rationale**: The posted information should not need to be frequently updated, and 30 days should be sufficient and timely.

<u>Preventive Services Requirement:</u>
What preventive services does this new requirement apply to?
Colorado statute (C.R.S. 10-16-104(18)) defines preventive services as:

- Unhealthy alcohol use screening for adults;
- Depression screening for adolescents and adults;
- Perinatal maternal counseling for persons at risk;
- Cervical cancer screening;
- Cholesterol screening for lipid disorders;
- Colorectal cancer screening coverage for tests for the early detection of colorectal cancer and adenomatous polyps;
- Child health supervision services;
- Childhood immunizations;
- Influenza vaccinations;
- Pneumococcal vaccinations;
- Tobacco use screening of adults and tobacco cessation interventions by primary care providers;
- Any other preventive services included in the A or B recommendations of the U.S. Preventive Task Force or required by federal law.

Preventive services must be provided in accordance with the A or B recommendations of the U.S. Preventive Task Force for the particular preventive service, with the exception of colorectal cancer screening for those at high risk. A bulletin from the Division of Insurance on preventive services can be found here.

- **Rationale**: Pulled from statute.

What if a preventive service begins as screening and turns into a diagnostic procedure – can we charge facility fees for the diagnostic procedure (for example, routine colonoscopy begins as screening but turns into a diagnostic procedure).

CHA would recommend following how the insurance company directs you to bill in these situations (i.e., if you bill as preventive or diagnostic). For example, Medicare has established modifier PT, which denotes when a service began as a colorectal cancer screening test and then was moved to a diagnostic test due to findings during the screening. In this instance, the entire visit is considered diagnostic (and not preventive) as the modifier PT is appended to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening sigmoidoscopy HCPCS code.

Under the transparency requirements, you must provide the estimated facility fee charge for a preventive service. This would be $0 for all covered patients, but you should include a disclaimer for applicable preventive health services (e.g., colonoscopy) that the procedure could turn into a diagnostic procedure, upon which the patient may receive a facility fee charge.

- **Rationale**: How this situation is billed changes based on direction from the insurance company.

How would the preventive services ban work for uninsured patients? Would it not apply to them?

It is unclear how this language applies to the uninsured population. One interpretation is that it wouldn’t apply to uninsured patients since the language specifically references situations in which a patient’s insurance does not cover preventive health care services. On the other hand, this section could be interpreted to prohibit a facility from billing, charging, or collecting the facility fee component of a preventive service from an uninsured patient since a facility fee would not be covered by an individual’s insurance if the patient is uninsured. CHA recommends that members connect with their own legal representation.

- **Rationale**: The statute is unclear.