COLORADO RURAL HEALTH CENTER
Celebrating 30 Years 1991-2021
The State Office of Rural Health

2021 Legislative Session Summary

This report provides an overview of the 2021 Colorado legislative session for members of the Colorado Rural Health Center (CRHC). The report summarizes 24 bills related to or impacting rural health that CRHC took a position on during session. CRHC bill positions, which are decided by majority vote by the CRHC Policy & Legislative Committee (PLC) and approved by the CRHC Board of Directors, are included after each bill summary. The CRHC Policy Priority is also listed after each bill summary. If applicable, CRHC lobbying activities are included after each bill summary. Lobbying activities listed are not inclusive of all advocacy activities undertaken by CRHC. The bills are linked to Colorado Capitol Watch, where you can find the most recent bill text, fiscal note, bill history and bill sponsors.

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Session Overview

The 2021 Colorado legislative session began on January 13, 2021, convened for three days to pass pressing legislation, and then temporarily adjourned due to COVID health precautions. The General Assembly reconvened on February 16, 2021 and adjourned for the year on June 6, 2021. Of the 623 bills introduced, 502 bills (81%) passed. This compares to 2020 when 652 bills were introduced, 329 bills, or 51% passed. The considerable increase in passage rates is due to trifecta control of the House, Senate and Governor's Office by Democrats, and by the thrush of federal funding via COVID relief bills.

Prior to the start of the 2021 session, CRHC convened members to identify key priorities for our legislative work. Over 40 members participated in the meeting and identified eight major priority areas, including reimbursement, regulatory impediments, workforce, primary care, Medicare and Medicaid coverage, COID-19, consumer healthcare costs and affordability, quality programs and reporting, HIT and technology infrastructure, and specialty care. Using these priorities as guide, we evaluated each bill's potential impacts on the ten priorities and strategized our lobbying and advocacy efforts accordingly.

CRHC tracked 75 bills this session, voting to take positions on 24 bills, each corresponding to a CRHC policy priority. CRHC supported ten bills, opposed three bills and monitored eleven bills. 90% percent, or ten bills that CRHC supported passed, and 60% of bills CRHC opposed failed. Throughout the session, CRHC testified eight times, issued one state policy action alert, and attended or hosted over 70 policy and stakeholder meetings. CRHC also hosted our second annual Rural Advocacy Day, virtually facilitating six meetings between CRHC members and state policy leaders.

Going into the 2021 session, healthcare providers and advocates were working tirelessly to address the COIVD-19 pandemic. What was intended to be a difficult year economically for the state quickly turned around; the state's economic recovery happened far more quickly than expected, and the state received billions in federal relief funding. Policymakers on both sides of the aisle were laser-focused on legislative solutions to the pandemic and succeeding economic impacts, which were felt far differently in urban and rural regions of the state. Following the short recess, Democrats took up an ambitious healthcare policy strategy, mostly

informed by Governor Polis' [Roadmap to Saving Coloradans Money on Healthcare.](#) The roadmap outlined legislation related to prescription drug savings, lowering hospital prices, bolstering the reinsurance program, and passing a public healthcare option.

Even in this difficult environment, CRHC worked hard to advocate for rural healthcare providers and the communities they serve. We continued to champion legislation aligned with our policy priorities, and shared in a number of big wins, including helping to pass legislation to speed up the credentialing process, collaborating on a dental telehealth bill that will increase both revenue for providers and access to care for consumers, and most significantly, working with state partners and fellow provider groups to shape the public option legislation, which is discussed extensively at the end of this report. The work has not ended since the session has concluded, and we will continue to advocate for our members on both the state and federal level. We've already got big plans for next year's session!

Healthcare Facility Policies & Protocols

SB21-126 Timely Credentialing Of Physicians by Insurers intends to solve the long-standing issue CRHC members have been experiencing with long and uncertain wait times for credentialing of new providers by private insurance companies. The bill establishes timelines and parameters that insurance carriers must follow in considering applications for physicians to participate in their networks, including that an application process must be concluded within 60 calendar days of receiving the application. The Colorado Medical Society led the bill, working in partnership with the Colorado Association of Health Plans to negotiate the credentialing timeline outlined in the bill, as follows:

- 60 days to conclude the credentialing process and notify the applicant.
- 7 days from the carrier receiving an application for them to notify the applicant of said receipt.
- 10 days from receipt for the carrier to notify an applicant if the application is incomplete and provide the applicant with a detailed list of all items required to complete the application.
- If the carrier does not notify the applicant within the required timeframes and the carrier concludes the credentialing process, the applicant shall be considered a participating provider no later than 50 days from receipt.
- 30 days for the carrier to correct discrepancies in the network plan directory after a report of the discrepancy from a participating provider.

- All credentialing criteria made available by the carrier to all applicants and posted on their website.
- A participating provider remains credentialed and loaded in the carrier's billing system unless the carrier discovers information that the provider no longer meets their participation guidelines. Notification of a change in credentialing status must be made in writing with an explanation.

The bill served as a big win for rural health this session and sailed through the legislative process with almost no opposition. The legislation was framed as a means to increase healthcare efficiency and ultimately access. Legislators on both sides of the aisle lauded the bill for its robust stakeholder process and bipartisanship. CRHC provided invaluable support and member feedback during the formative stage of the bill in the summer of 2020. During the 2021 legislative session, CRHC testified in support of the legislation in multiple Senate and House committees, working with bill sponsors and proponents and tracking the bill through the legislative process.

CRHC Positon: **SUPPORT**
CRHC Policy Priority Area: Regulatory Impediments
Final Actions: Governor Signed July 6, 2021
Effective date: September 6, 2021
CRHC Lobbying Activities: CRHC testified twice in support of the bill in House and Senate health committees. CRHC worked closely with bill proponents, including CMS, to provide feedback from members as the legislation was developed.

HB21-1172 **Hospital Patient Long-term Care Resident Visit Rights** was introduced in response to restricted visitor access at Colorado hospitals and long-term care facilities due to COVID-19 safety precautions. Healthcare providers across the country struggled to balance the social and emotional well-being of patients and residents with the health and safety of their staff. The bill intended to circumvent CDC guidance and internal visitation policies by requiring health care facilities, including hospitals, nursing care facilities and assisted living residences, to allow their patients and residents to have at least one visitor of their choosing. Further, the bill prohibited healthcare facilities from disallowing visitation if the sole reason is to reduce the risk of transmission of a pandemic disease, but would have allowed healthcare facilities to impose requirements and limitations on visitors to reduce the risk of transmission of a pandemic disease.

PLC members indicated that clinical decisions to put restrictions in place over the past year were not made lightly, and were aligned with local, state, federal, and global public health guidance to minimize spread of the virus and to protect patients, visitors and staff. Moreover, Medicare Conditions of Participation (COP) mandate all hospitals and long-term care facilities have policies governing patient visitation. Failure to comply with this federal mandate can result in significant fines and/or termination of participation in the Medicare and Medicaid programs, which would effectively close a hospital or long-term care facility.

CRHC joined with a coalition of healthcare provider and advocacy groups to oppose the legislation. The coalition sent a letter to members of the House Health & Insurance Committee asking members to respectfully reject the legislation. Ultimately, the bill was postponed indefinitely by the committee down a party line vote of 8-5.

CRHC Positon: **OPPOSE**
CRHC Policy Priority Area: Regulatory Impediments, COVID-19
Final Actions: House Committee on Health & Insurance postponed indefinitely on April 21, 2021.

Healthcare Costs & Affordability

SB21-123 **Expand Canadian Rx Import Program** authorizes Healthcare Policy & Financing to expand the drug importation program to allow prescription importation from nations other than Canada. In 2019, the Colorado General Assembly enacted SB19-005, which created the Canadian Prescription Drug Importation Program in HCPF. The legislation and subsequent program, which CRHC supported in 2019, intends to reduce prescription drug costs in the state by importing certain drugs from Canada. Pending federal approval, the program directs HCPF to annually establish a wholesale prescription drug importation list that identifies the prescription drugs that have the highest potential for cost savings to the state. Drugs eligible for the program must meet U.S. standards related to the drug's safety, effectiveness, misbranding, and adulteration, and the importation of the drug must not violate federal patent laws. Upon selection of the drugs, HCPF must enter into an agreement with a perception wholesaler to make the drugs available to Coloradans.

After the passage of the legislation, Canada's Ministry of Health indicated that certain drugs would be prohibited from being distributed outside of Canada if it would cause or worsen a shortage of the drug. Recognizing this may hamper Colorado's ability to import certain drugs,

HCPF sought to expand the importation program to nations other than Canada via this legislation. CRHC was approached by HCPF to support the legislation, which the PLC and CRHC Board of Directors approved. Subsequently, HCPF and bill proponents touted CRHC's support in multiple committees.

CRHC Positon: **SUPPORT**
CRHC Policy Priority Area: Consumer Healthcare Costs & Affordability
Final Actions: Governor Signed on April 26, 2021
Effective Date: The program is still awaiting federal approval to initiate importation of drugs.

HB21-1307 **Prescription Insulin Pricing and Access** builds upon current law, passed in 2019 with CRHC support, which states an insulin drug (singular) may not exceed $100/month. This new bill states drugs (plural) may not exceed $100/month, regardless of the type of insulin or number of prescriptions. The cap on insulin pricing required by the 2019 bill is only available to state-regulated insurance plans. There are three primary markets that are subject to state regulation: the individual, small-group, and large group markets, with the exception of self-insured employers. About one million Coloradans receive health insurance through such plans. The bill does not apply to Medicare, Medicaid, military plans, or self-insured employer-based health plans, which are regulated by the federal government.

In order to provide insulin savings for more Coloradans, this bill creates the Emergency Insulin Supply program, which allows eligible individuals to receive an emergency 30-day supply of insulin once per 12-month period for no more than a $35 copay. The bill also creates the Insulin Affordability program, which allows eligible individuals to receive a 12-month prescription for insulin for no more than a $50 copay for a 30-day supply. These programs will be made available to Coloradans not currently eligible for the 2019 insulin cap. PLC members noted insulin affordability continues to be an issue for their patients, as the prices continue to increase while the formulary has stayed relatively the same.

CRHC Positon: **SUPPORT**
CRHC Policy Priority Area: Consumer Healthcare Costs & Affordability
Final Actions: Sent to the Governor on June 15, 2021
Effective Date: The bill takes effect 90 days following adjournment of the General Assembly sine die, which is September 6, 2021, assuming no referendum petition is filed. The Insulin Affordability Program and the Emergency Insulin Supply program are created effective January 1, 2021.

[SB21-175](SB21-175) **Prescription Drug Affordability Review Board** builds off of Governor Polis's 2020 Roadmap to Saving People Money on Healthcare, which explicitly includes the creation of a prescription drug affordability board tasked with utilizing prescription drug price transparency data to identify prescription drugs that pose affordability burdens to Coloradans. The bill was championed by consumer advocates and hard fought by the prescription drug industry and some healthcare facility and provider groups.

The board consists of five members to be appointed by the Governor and confirmed by the Senate, and is charged with reviewing prescription drug affordability data and creating caps on drug costs. The board may not establish upper payment limits for more than 12 prescription drugs each year starting April, 2022. A fifteen-member Prescription Drug Affordability Advisory Council is also established to provide stakeholder input to the board.

The bill specifies drug types and cost thresholds that trigger a board inquiry into whether an affordability review is required, as well as criteria for making that decision. In performing a review, the board is required to consider determinants of cost, availability of alternatives, and a variety of market characteristics listed in the bill, which may be further delineated in rule by the board. Beginning January 1, 2022, it will be unlawful to purchase a prescription drug at a cost that exceeds the cap established by the board except for personal or familial use, enforceable by the State Attorney General. The pricing cap may be appealed within sixty days after the cap is announced.

Beginning in 2022, applicable health insurance carriers and pharmacy benefit management firms must report prescription drug cost information to the All-Payer Health Claims Database (APCD). The APCD must then provide this information to the Commissioner of Insurance in the Department of Regulatory Agencies (DORA). This information, which is detailed in the bill, includes volume, total cost, average cost, and year-over-year drug price increases

A drug manufacturer may withdraw a drug for which an upper payment limit has been established from sale or distribution in the state, but they must provide at least 180 days of written notice to the Commissioner of Insurance and Attorney General. The Commissioner may fine a manufacturer up to $500,000 for failure to provide notice of the withdrawal of a drug.

While PLC members recognized a need to reduce prescription drug costs, members expressed fear that a drug manufacturer may withdraw certain high-cost drugs from the Colorado market, which would effectively make the drug unavailable to Colorado consumers, even if their

providers deem the drug necessary. This significant potential consequence led PLC members to a Monitor positon on the bill.

CRHC Positon: MONITOR
CRHC Policy Priority Area: Consumer Healthcare Costs & Affordability
Final Actions: Governor Polis signed on June 16, 2021
Effective Date: The Governor must appoint board members by October 1, 2021, and the first meeting must take place within 6 weeks after the board appointments. Beginning January 1, 2022, it will be unlawful to purchase a prescription drug at a cost that exceeds the cap established by the board. The bill and subsequent program, board and pricing caps are slated to repeal at the end of 2027, unless further legislation is passed.

HB21-1198 **Health-care Billing Requirements for Indigent Patients** expands hospital requirements around providing discount care to uninsured patients and moves regulatory authority over the program from CDPHE to HCPF. Changes to the program include:

- Applying regulations to all healthcare facilities, instead of just hospitals.
- Requiring HCPF to develop a standard application for healthcare facilities to screen uninsured patients for eligibility for public health insurance programs, CCIP or discounted care.
- Creating an appeals process if a patient is found to be ineligible.
- Limiting the amount that a healthcare facility can charge eligible patients to not more than the discount rate established by HCPF.
- Limiting collection amounts to monthly payments of no more than 4% of the patient's monthly household income on a bill from a health care facility and not paying more than 2% of the patient's monthly household income on a bill from a licensed healthcare professional.
- Considering a patient's bill paid in full after 36 months of payments.
- Requiring healthcare facilities to post information on patient's rights under the discount program, as developed by HCPF.
- Requiring healthcare facilities to report certain information to HCPF to determine compliance across demographics.
- Requiring HCPF to periodically review healthcare facilities to ensure compliance.
- Requiring HCPF to promulgate rules prohibiting hospitals from considering assets when determining if a patient's income eligibility and to ensure the method used to determine eligibility is uniform across hospitals.

The bill also makes changes to how medical debt may be collected by a healthcare facility. A medical creditor or medical debt collector cannot engage in any permissible extraordinary collection actions until 182 days after the date the patient receives hospital services. In addition, 30 days before taking an action, a creditor must notify the patient of potential collection actions and provide the patient with a notice explaining the availability of discounted care for qualified individuals developed by HCPF.

PLC members recognized the need to formalize the financial aid screening process for all healthcare providers, however, the additional reporting requirements and the reformed collection limits led members to a Monitor position.

CRHC Positon: MONITOR
CRHC Policy Priority Area: Consumer Healthcare Costs & Affordability
Final Actions: Sent to the Governor on June 22, 2021
Effective Date: By April 1, 2022, the Medical Services Board in HCPF must promulgate rules to implement the program and HCPF must develop information on patient's rights, establish a process for patients to appeal a determination of ineligibility, establish rates for discounted care, and begin to periodically review health care facilities for compliance. By June 1, 2023, and each June 1 after, each health care facility must collect and report data to HCPF on compliance.

Telehealth and Broadband

SB21-139 **Coverage for Telehealth Dental Services** was another big win for CRHC during this legislative session! SB20-212 Reimbursement for Telehealth Services, which passed in the 2020 session with CRHC support, required Medicaid and state-regulated insurance plans to reimburse RHCs at in-person rates for services provided by telehealth. Prior to the passage of SB20-212, RHCs were not reimbursed for telehealth services. SB21-139 expands the 2020 bill by requiring Medicaid, CHP+ and state-regulated insurance plans to provide in-person reimbursement rates for dental services provided via telehealth. The bill also prohibits these payers from imposing annual expenditure maximums for telehealth dental services or instituting any cost-sharing that exceeds those for an in-person visit.

Nothing in the bill requires the use of telehealth when a provider determines that delivery of care through telehealth is not appropriate or when a covered person chooses not to receive care through telehealth.

CRHC was approached by bill sponsors and proponents to support the bill, and after approval from the PLC and Board for a Support position, CRHC signed onto support fact sheets and testified in committee hearings in either chamber. During testimony, CRHC underscored the significance of teledental services in rural, especially for e-consults between hygienists and dentists and in long-term care settings. The bill encountered very little opposition, with payers recognizing there would be no increase in utilization and the potential to glean savings from better oral health outcomes.

CRHC Positon: SUPPORT
CRHC Policy Priority Area: Reimbursement
Final Actions: Governor Signed on May 7, 2021
Effective Date: The bill applies to dental plans issued or renewed in Colorado on or after May 7, 2021.
CRHC Lobbying Activities: CRHC testified twice in support of the bill in House and Senate health committees. CRHC attended stakeholder meetings and met with bill proponents to provide member feedback as the legislation was developed.

HB21-1256 **Delivering Health-care Services Through Telemedicine** directs HCPF to promulgate rules specifically relating to entities that deliver healthcare or mental healthcare services exclusively or predominately through telemedicine. The bill is limited to Medicaid fee for service and does not include managed care.

Current law states that in-person contact between a healthcare provider or mental healthcare provider and a patient is not required under the state's Medicaid program for services delivered through telemedicine that are otherwise eligible for reimbursement under Medicaid.

Since COVID-19, new entities have entered the telehealth realm. Some have no brick and mortar in Colorado or otherwise, but are contracting with Colorado providers. The issue is these exclusive telehealth providers don't circle back into the medical home, which can raise the risk of less integrated, patient-centered care. The bill empowers HCPF to promulgate rules for these specific providers.

HCPF approached CRHC to support the legislation, noting a need to strike a balance between encouraging the use of telehealth while discouraging the utilization of telehealth providers who do not provide in-person care in the state.

CRHC Positon: SUPPORT

CRHC Policy Priority Area: Reimbursement
Final Actions: Governor Signed on May 27, 2021
Effective Date: The bill takes effect on May 27, 2021, the bill language does not indicate when HCPF will begin the promulgation of the new rules.
CRHC Lobbying Activities: CRHC testified twice in support of the bill in House and Senate health committees. CRHC attended stakeholder meetings and met with bill proponents to provide member feedback as the legislation was developed.

HB21-1289 **Funding for Broadband Deployment** utilizes federal COVID relief funds to support four broadband grant programs. The bill also codifies Colorado Broadband Office in the Office of Information Technology (OIT) as a Type 1 entity to serve as the central broadband policy coordination body for the state. In a type 1 transfer, an agency or part of an agency is transferred intact to another principal department. The transfer creates a relationship in which the subordinate agency is administered under the direction and supervision of that principal department but exercises its powers, duties, and functions independently of the head of that department. The most important powers an agency retains with a type 1 transfer – powers that may be exercised in whatever way the agency determines, even without the approval of the executive director – are the promulgation of rules and standards and the rendering of administrative findings, orders, and adjudications. Type 1 transfer powers also include regulation, licensing, and registration. However, the executive director of the department has all "budgeting, purchasing, planning, and related management functions" and any powers, duties, and functions not specified by statute as belonging to the agency being transferred are performed under the direction and supervision of the head of the principal department.

The four grant programs supported by the bill include:

1. **Digital Inclusion Grant Program**-OIT will administer the Digital Inclusion Grant Program to increase broadband access, speeds, reliability, and affordability. The program utilizes $35 million in federal American Rescue Plan Act (ARPA) funds to award grants of up to $20 million to one or more Indian tribes or nations for deploying infrastructure and devices, and up to $15 million to one or more providers of telehealth services.
2. **Broadband Stimulus Grant Program**—DORA will administer the Broadband Stimulus Grant Program, which will utilize $35 million in ARPA funds to supplement the existing grant program.

3. **Interconnectivity Grant Program**—DOLA will administer the Interconnectivity Grant Program, which will utilize $5 million in ARPA funds to award funding to local governments for projects focused on regional broadband infrastructure needs.
4. **Connecting Colorado Students Grant Program**. The bill also extends grant distribution and reporting deadlines for the Connecting Colorado Student Grant Program.

CRHC Positon: MONITOR
CRHC Policy Priority Area: HIT & Technology Infrastructure
Final Actions: Governor signed on June 28, 2021
Effective Date: All grant funds are intended to be awarded by the end of 2021. Each grant administrating body, including OIT, DORA and DOLA will be required to submit annual reports to the Governor, the Joint Budget Committee, and the Joint Technology Committee on the implementation of the grant program, with the first report due January 1, 2022.

Mental Health & Substance Abuse

SB21-122 Opiate Antagonist Bulk Purchase and Standing Orders expands eligibility for the types of entities that may purchase Naloxone and Narcan from the state's bulk purchase program. Previous law allowed only certain entities to purchase opiate antagonists through the opiate antagonist bulk purchase fund and also allows specific entities to receive opiate antagonists pursuant to standing orders and protocols. The bill aligns these sections of law so that:

- A unit of local government may purchase opiate antagonists through the fund pursuant to a standing order and protocol; and
- A harm reduction organization, law enforcement agency, or first responder to which opiate antagonists have been prescribed or dispensed through a standing order and protocol may purchase the opiate antagonists through the fund.

Eligible entities may purchase opiate antagonists and little or no cost through CDPHE's dedicated website. All eligible entities must have a current standing order in place prior to submitting an application. Click the link to request a standing order.

Eligible entities include, but are not limited to: local public health agencies, school districts, harm reduction agencies, law enforcement, and entities with publicly accessible AEDs, which include but are not limited to public universities, recreation centers, shopping centers, and workplaces. Ineligible entities include healthcare settings and pharmacies.

While healthcare settings are exempt from the program, PLC members felt it was important to support the legislation to provide community partners access to these critical drugs.

CRHC Positon: SUPPORT
CRHC Policy Priority Area: Mental & Behavioral Health
Final Actions: Governor signed on April 15, 2021
Effective Date: The bill took effect upon signature of the Governor on April 15, 2021.

HB21-1068 **Insurance Coverage Mental Health Wellness Exam** requires all state regulated insurance plans to provide coverage for the total cost of an annual 60 minute mental health wellness exam by an eligible provider, which includes:

- Physician who has certification or training in psychiatry or mental or behavioral health
- Physician assistant who has training in psychiatry or mental health
- Psychologist
- Clinical social worker
- Marriage and family therapist
- Licensed professional counselor
- Addiction counselor
- Advanced practice registered nurse, with specific training in psychiatric nursing

The provisions of the bill apply to health insurance plans that are subject to state regulation. There are three primary markets that are subject to state regulation: the individual, small-group, and large-group markets, with the exception of self-insured employers. CHP+ enrollees and those with Colorado state employee insurance, currently through Kaiser Permanente, subject to state regulation and would be required to expand coverage in accordance with the bill. In total, about one million Coloradans receive health insurance through such plans. The bill does not apply to Medicare, Medicaid, military plans, or self-insured employer-based health plans, which are regulated by the federal government.

Mental and behavioral health has been a significant policy priority for CRHC for many years. Various iterations of this bill have been introduced during the last three legislative sessions and received CRHC support, however, they did not pass due to concerns that the additional benefits that must be covered by the bill may potentially increase health insurance costs across the state. To address this concern, this year's bill requires the Division of Insurance to conduct an actuarial study to determine the effects this required coverage has on premiums.

While parity between mental and physical healthcare coverage is a requirement under the ACA, carriers were not required to provide coverage for the total cost of such services. The bill delivers a pathway to true parity by providing individuals the opportunity to set up a relationship with a mental health provider. It also creates infrastructure for individuals struggling with mental challenges before they are faced with a mental health crisis. The broad variety of providers who can provide the exam in the bill is especially significant to rural communities.

CRHC was very active in supporting this legislation, in this session and in previous. We have worked with the bill sponsor to broaden the types of providers who may provide the exam, signed on to multiple fact sheets and letters of support, and testified in House and Senate committees.

CRHC Positon: SUPPORT
CRHC Policy Priority Area: Mental & Behavioral Health
Final Actions: Governor signed on July 6, 2021
Effective Date: The bill took effect upon signature of the Governor on July 6, 2021.
CRHC Lobbying Activities: CRHC testified twice in support of the bill in House and Senate health committees. CRHC attended stakeholder meetings and met with bill proponents to provide member feedback as the legislation was developed.

SB21-011 **Pharmacist Prescribe Dispense Opiate Antagonist** aims to reduce opioid overdoses and abuse by requiring pharmacists who dispense opioids to inform individuals of the potential dangers of a high dose of an opioid, and offer to dispense them an opiate antagonist if the individual is also prescribed a benzodiazepine, a sedative hypnotic drug, carisoprodol, tramadol, or gabapentin the opioid prescription being dispensed is 90 morphine milligram equivalent or greater.

Pharmacists must also notify these individuals of available generic and brand-name opiate antagonists. The bill does not apply to pharmacists dispensing medication to a patient who is in hospice or palliative care, or to residents in veteran community living centers.

While the bill does require additional duties for pharmacists when dispensing and counseling on the use of opioids, PLC members felt the enhanced requirements were a reasonable means of reducing opioid abuse and overdoses.

CRHC Positon: SUPPORT
CRHC Policy Priority Area: Mental & Behavioral Health

Final Actions: Governor signed on June 4, 2021.
Effective Date: The bill takes effect 90 days following adjournment of the General Assembly, which is September 6, 2021.

HB21-1258 Rapid Mental Health Response for Colorado Youth leverages $9 million in federal COVID-19 relief funding to provide all Colorado youth access to temporary mental health services. Colorado ranks 48th in the country in an overall measure of the mental health of its youth, with rural youth almost twice as likely to commit suicide as their rural peers. The same data found Colorado to have the highest prevalence of youth alcohol dependence and illicit drug use in the country. The impact of the COVID-19 pandemic has exacerbated these statistics, with calls to the Colorado crisis services line increasing by 30% since March 2019.

The bill establishes the Temporary Youth Mental Health Services Program within the Office of Behavioral Health (OBH). The program will reimburse providers for providing up to three mental health sessions to youth screened into the program. The OBH must develop a process to select providers, determine a reasonable reimbursement rate, and implement a statewide public awareness outreach campaign. The OBH must enter into an agreement with a vendor to create or use an existing web based portal made available to youth, likely to be the current crisis services call and text line. The portal must have an age-appropriate mental health screening, allow providers to register and share appoint availability, connect youth to providers who will accept the youth's insurance, and allows a youth to schedule an appointment regardless of insurance status. Because the program is funded by one-time federal dollars, the program is repealed June 30, 2022.

The bill was sponsored by the same legislator who carried HB21-1068 Coverage for Mental Health Wellness Exam. CRHC worked with the sponsor to ensure rural Colorado youth would have access to these mental health visits by lobbying for the services to be provided both in-person and via telehealth. CRHC signed onto multiple fact sheets and testified in House and Senate Committees.

CRHC Positon: SUPPORT
CRHC Policy Priority Area: Mental & Behavioral Health
Final Actions: Senate Committee on Appropriations Postponed Indefinitely on 6/10/2020
CRHC Lobbying Activities: CRHC testified twice in support of the bill in House and Senate health committees. CRHC attended stakeholder meetings and met with bill proponents to provide member feedback as the legislation was developed.

SB21-137 Behavioral Health Recovery Act is a massive, sweeping piece of legislation that leverages $550 million in federal COVID-19 relief funds to expand behavioral health services in the state. The bill creates the Behavioral and Mental Health Cash Fund (BMH Fund) to draw down the $550 million in federal funds and directs spending to the following programs:

Within the Department of Human Services:

- **Early Childhood Mental Health Consultation Program.** The DHS is required to hire contractors for evaluation, gap analysis, and development of a financing strategy for the program. Costs are from the General Fund and annualize to $280,000 in FY 2023-24 and $326,000 in FY 2024-25.
- **Rural Behavioral Health Vouchers.** The DHS must hire a nonprofit contractor offering behavioral health services. The bill allocates $50,000 in FY 2021-22 and $50,000 in FY 2022-23.
- **Recovery Residence Certification.** The DHS must hire a contractor for certification and training on industry best practices for recovery residences. The bill allocates $200,000 in FY 2021-22 and $200,000 in FY 2022-23.
- **Treatment and Detoxification Programs.** The bill appropriates $200,000 in FY 2021-22 for these programs in the OBH.
- **Housing Assistance Program.** The DHS must establish a program providing temporary housing assistance to certain individuals with a SUD. The bill allocates $4,000,000 in FY 2021-22 and $4,000,000 in FY 2022-23.
- **Recovery Support Services Grant Program.** The DHS must provide recovery-oriented services to individuals with a substance use and co-occurring mental health disorder. The bill allocates $1,600,000 in FY 2021-22 and $1,600,000 in FY 2022-23.
- **Maternal and Child Health Pilot Program.** The bill continues this pilot program and requires that funding from the MTCF be appropriated annually. The bill allocates $652,376 in FY 2022-23, a figure that is based on the most current expenditures of the pilot program.
- **Managed Service Organizations.** The bill appropriates $10,000,000 in FY 2021-22 for substance use disorder treatment and recovery providers.
- **Community Mental Health Centers.** The bill appropriates $3,250,000 in FY 2021-22 for unanticipated expenses related to COVID-19.
- **Colorado Crisis System.** The bill allocates $5,000,000 in FY 2021-22 to the crisis system to support its response to COVID-19 on the behavioral health of residents, including for youth crisis system access.

- **Community Mental Health Centers.** The bill appropriates $2,000,000 in FY 2021-22 to community mental health centers for services provided to children and parents by school-based providers.
- **High-Risk Families.** The bill appropriates $3,000,000 in FY 2021-22 to the High Risk Families Cash Fund.
- **Mental Health Awareness Campaign.** The bill appropriates $1,000,000 in FY 2021-22 for a mental health awareness campaign.
- **Workforce Development Program.** The bill appropriates $18,000,000 in FY 2021-22 for a workforce development program in OBH to recruit, retain, and train the behavioral health workforce.
- **Statewide Care Coordination Infrastructure.** The bill appropriates $30,000,000 in FY 2021-22 for OBH to develop coordination infrastructure for uninsured and publicly funded clients.
- **Co-responder Programs.** The bill appropriates $10,000,000 in FY 2021-22 for Colorado Crisis System services, housing assistance, and treatment for rural communities.
- **Treatment Funding**. The bill appropriates $2,000,000 in FY 2021-22 to the OBH for behavioral health and substance use disorder treatment for children and their families.
- **Community Transition Services.** The bill appropriates $500,000 in FY 2021-22 for guardianship services for individuals transitioning out of mental health institutes.
- **Jail Based Behavioral Health Services.** The bill appropriates $5,000,000 in FY 2021-22 for jail-based behavioral health services.
- **Childhood Mental Health.** The bill appropriates $500,000 in FY 2021-22 for the Early Childhood Mental Health Consultation Program.
- **Ombudsman.** The bill appropriates $300,000 in FY 2021-22 to help solve behavioral health access and coverage concerns or complaints from consumers and providers.

Within the Department of Higher Education:

- **Medication-Assisted Treatment Expansion Pilot Program.** The bill continues the program and appropriates $3,000,000 in FY 2021-22 and $3,000,000 in FY 2022-23.
- **CSU AgrAbility Project.** The bill expands this program to provide rural mental health support to farmers and their families and requires appropriations of $900,000 in FY 2021-22 and $900,000 in FY 2022-23.
- **Public Awareness Campaign.** The bill continues the statewide public awareness campaigns related to safe medication practices administered by the Center and requires appropriations of $750,000 in FY 2021-22 and $750,000 in FY 2022-23.

- **Center for Research into SUD.** The bill extends funding for the Center beyond the current expiration in statute, and includes an annual appropriation of $250,000 starting in FY 2024-25.
- **Perinatal Substance Use Data Linkage Project.** The bill allocates $75,000 in FY 2021-22 to an institute of higher education to connect state and non-state data sources to improve population-level estimates of perinatal substance exposure.
- **Center for Research into SUD.** The bill appropriates $1,000,000 in FY 2021-22 for training health care professionals to promote use of evidence-based models, grant-writing assistance, and recovery programs.
- **Regional Health Connector Workforce Program.** The bill appropriates $1,000,000 in FY 2021-22 to finance this newly created program.
- **Training on Opioid Use Disorder Medication.** The bill appropriates $630,000 in FY 2021-22 for training and support for health care providers concerning medication for opioid use disorder.

Within the Department of Public Health & Environment (CDPHE):

- **STI, HIV, and AIDS program.** The bill appropriates $500,000 in FY 2021-22 for operating expenses in the department's STI, HIV, and AIDS program.
- **Mental Health First-aid.** The bill appropriates $250,000 in FY 2021-22 for in person and virtual trainings by the Colorado Behavioral Health Care Council.
- **Colorado Health Service Corps.** The bill allocates $2,700,000 in in FY 2021-22 and $1,000,000 in FY 2022-23 for the loan repayment program.
- **Opiate Antagonist Bulk Purchase Fund.** The bill appropriates $1,000,000 in FY 2021-22 for bulk purchase of opiate antagonist medication.
- **Colorado HIV and AIDS Prevention Grant Program.** The bill appropriates $2,000,000 in FY 2021-22 for this grant program.
- **School-based Health Centers.** The bill appropriates $1,200,000 in FY 2021-22 for school-based health centers.

Within the Department of Healthcare Policy & Financing (HCPF)

- **MCO Service Modifications.** The bill sets various requirements on managed care organizations, which will increase HCPF costs for outreach by $67,920 in FY 2021-22 and $67,920 in FY 2022-23.
- **Screening for Perinatal Mood and Anxiety Disorder.** The bill allocates $156,438 in FY 2021-22 and $156,438 in FY 2022-23 to increase the number of covered screenings under Medicaid from 3 to 4.

- **Utilization Management for Inpatient Substance Use Disorder Treatment.** The bill allocates $1,253,501 in FY 2021-22 and $979,142 in FY 2022-23 for HCPF to develop a standardized processes to determine medical necessity for residential or inpatient substance use disorder treatment.
- **Audits for Denials for Inpatient Substance Use Disorder Treatment.** The bill allocates $463,123 in FY 2021-22 and $464,113 in FY 2022-23 for HCPF to hire a contractor to audit one-third of denials.
- **Care Coordination.** The bill allocates $94,245 in FY 2021-22 and $96,228 in FY 2022-23 for HCPF and DHS to develop statewide care coordination infrastructure.
- **Training.** The bill appropriates $250,000 in FY 2021-22 for training health care professionals in substance use screening, brief intervention, and referral to treatment.

In addition, the bill makes several other changes in law, including:

- Continuing the requirement for opioid prescribing limitations.
- Making the Harm Reduction Grant Program Fund continuously appropriated to the Colorado Department of Public Health and Environment (CDPHE).
- Continuing the Building Substance Use Disorder Treatment Capacity in Underserved Communities Grant Program indefinitely and repealing its July 1, 2024, repeal date.
- Requiring the Perinatal Substance Use Data Linkage Project to use additional data sources from state-administered programs when examining issues related to pregnant and postpartum women with substance use disorders and their infants.
- Continuing the public awareness campaign about safe storage of opioid medication beyond the program's September 1, 2024, repeal date.
- Requiring state and private prisons to provide at least two doses of an opioid reversal medication upon release to individuals that were treated for opioid use disorder while in custody, as funding and supplies allow.
- Removing fire stations from the list of safe stations at which an individual can turn in controlled substances without legal liability for possession.
- Creating a task force to meet during the 2021 interim to develop recommendations for spending funds received from the American Rescue Plan Act (ARPA) on behavioral health.
- Repealing the authority of the Opioid and Other Substance Use Disorders Interim Study Committee to meet during the 2021 interim.

Clearly, this bill is extensive in funding but still ambiguous in exactly how each line item will be spent. Considering this, the bill requires the creation of a taskforce to meet during the 2021 interim to explore behavioral health services in the state. The task force, which is expected to convene in August 2021 and meet through January 2022, must issue a report with recommendations to the General Assembly and Governor on policies to create transformational change in the areas of behavioral health using these federal dollars. CRHC is planning to engage with the taskforce throughout the summer and share any opportunities for members to participate or weigh-in on how the funds are spent in rural.

CRHC Positon: MONITOR
CRHC Policy Priority Area: Mental & Behavioral Health
Final Actions: Governor signed on June 28, 2021
Effective Date: The bill took effect upon the signature of the Governor on June 28, 2021. The taskforce will convene in August 2021.

HB21-1276 **Prevention of Substance Use Disorders** makes several changes to healthcare coverage laws and prescribing limits, and utilizes Marijuana Tax Cash Fund dollars to address opioid and other substance use disorders.

Insurance Coverage Components
The bill requires insurance carriers to provide coverage for an atypical opioid or non-opioid medication that is approved by the FDA and prohibits carriers from mandating a covered person undergo step therapy or requiring pre-authorization.

The bill requires each health benefit plan to provide a cost-sharing benefit for a minimum number of physical therapy visits, occupational therapy visits, chiropractic visits, and acupuncture visits, at a cost-sharing amount not to exceed the cost-sharing amount for a primary care visit for non-preventive services.

Opioid Prescribing Limits
Under current law, an opioid prescriber is prevented from prescribing more than a seven-day supply of an opioid to a patient that has not had an opioid prescription in the last 12 months unless certain conditions apply. Under the same law, healthcare providers are required to query the PDMP before prescribing a second opioid fill. This law was scheduled to expire at the end of September 2021, the bill continue the prescribing limitation and PDMP query requirements indefinitely.

On or before November 1, 2021, Medical Boards within DORA must pass rules for their respective providers to limit the supply of a benzodiazepine that a prescriber may prescribe to a patient who has not been prescribed benzodiazepine in the last 12 months, with some treatment exceptions.

Education for providers
The bill authorizes the Center for Research into Substance Use Disorder Prevention, Treatment, and Recovery Support Strategies to include in its educational activities the best practices for prescribing benzodiazepines and the potential harm of inappropriately limiting prescriptions to chronic pain patients.

The bill directs OBH to convene a collaborative with institutions of higher education, nonprofit agencies, and state agencies to gather feedback on evidence-based prevention practices and other functions related to preventative health, to be funded from the Marijuana Tax Cash Fund. The office is required to report its progress to the General Assembly each September from 2022 to 2025, when the collaborative repeals.

The opioid use crisis has persisted in rural Colorado and remained a policy priority for CRHC. While PLC members expressed support for the insurance components of the bill, there were concerns that the prescribing limitations hamper the discretion of providers, and also could diminish access to these necessary drugs, especially for patients who have chronic pain or cannot use NSAIDs.

CRHC Positon: MONITOR
CRHC Policy Priority Area: Mental & Behavioral Health
Final Actions: Governor signed on June 28, 2021
Effective Date: The bill takes effect July 1, 2021, except the sections that affect health insurance take effect January 1, 2023. Colorado Substance Use Disorders Prevention Collaborative members will be selected summer 2021, with the first report of the Collaborative due September 2022.

HB21-1281 **Community Behavioral Health Disaster Program** is intended to enhance, support, and formalize behavioral health disaster preparedness and response activities of community behavioral health organizations. In May 2020, the Governor asked the Behavioral Health Task Force to establish a COVID-19 special assignment committee to develop key recommendations

for consideration in a future crisis. The committee determined that Colorado must maintain and enhance a coordinated behavioral health emergency disaster response and ensure the permanency of robust resources for preparedness and response. However, because there is no formal funding stream or management agency to oversee the program, the committee recommended a dedicated funding stream, approximately $560,000 in FY 2021-22 and FY 2022-23, to support the program.

CDPHE will promulgate rules as necessary to oversee the program, work with community behavioral health organizations to create, define, and publish eligibility criteria to participate in the program and administer the funding to community behavioral health organizations to help improve emergency preparedness.

The intent of disaster response is to promote individual, family, and community resilience and it helps affected individuals return to a pre-event level of functioning as quickly as possible. Disaster response methods include triage, basic support, psychological first aid, and making appropriate professional referrals in the community. These services are provided both to survivors and first responders, and the actual methods used depend on the type of event, the number of people affected, and the availability of resources.

PLC members voted for a Monitor position on the bill in recognition of the importance of community-wide preparedness for the next disaster, however, members also noted continuing problems working with community mental health centers across the state.

CRHC Positon: MONITOR
CRHC Policy Priority Area: Mental & Behavioral Health
Final Actions: Governor signed on June 28, 2021
Effective Date: The bill took effect upon signature of the Governor on June 28. The program is funded through FY 2023.

Provider Scope & Reimbursement

HB21-1275 **Medicaid Reimbursement for Services by Pharmacists** modifies the state's Medicaid program to include payment to pharmacists when working in a collaborative practice agreement with a physician. In addition, the bill authorizes Medicaid payments to pharmacists to administer or dispense extended-release injectable medications for treatment of mental health or substance use disorders.

There is a shortage in primary care providers in Colorado, especially providers who take Medicaid. Pharmacists can help address this shortage by providing certain primary care services as a follow-up to physician care through collaborative practice models, including the provision of chronic disease management. However, without reimbursement, the services pharmacists provide are not sustainable. PLC members recognized that while many of their facilities do not currently employ clinical pharmacists, expanded reimbursement through Medicaid may open the door for these providers to work at a CAH or RHC. CRHC signed onto a factsheet with the statewide association for Federal Qualified Health Centers in support of the bill.

CRHC Positon: SUPPORT
CRHC Policy Priority Area: Reimbursement
Final Actions: The bill takes effect 90 days following adjournment of the General Assembly, which is September 6, 2021.

HB21-1012 Expand Prescription Drug Monitoring Program directs the Board of Pharmacy in DORA to determine if the PDMP should track all prescription drugs prescribed in the state. Current law requires the PDMP to track all controlled substances prescribed in Colorado. If the Pharmacy Board makes such determination, it must promulgate rules by June 1, 2022. The board may exclude one or more prescription drugs from the program by publicly noting the justification for the exclusion.

The PDMP currently covers 45,700 practitioners, including dentists, doctors, nurses, optometrists, podiatrists, and veterinarians, who issue about seven million prescriptions annually for controlled substances. Operating costs for the program are paid as a PDMP surcharge on license renewal fees by these practitioners. The PDMP currently tracks approximately 7 million controlled substance prescriptions annually, the fiscal note estimates that if the program is expanded to include all prescriptions, the number could grow by as many as 35-40 million per year.

COHRIO approached CRHC to support the legislation, noting patient safety as the driving force of the legislation. Bill proponents claimed having a PDMP which collects all prescriptions provides the most comprehensive, up-to-date information available, and can help to reduce or prevent adverse drug events which can lead to hospitalizations or readmissions for patients and financial penalties for health care providers. However, PLC members expressed concern over

the additional reporting requirements for providers, and expressed concern for how the state may potentially use the data, which ultimately led to a Monitor position on the bill.

CRHC Positon: MONITOR
CRHC Policy Priority Area: Mental & Behavioral Health
Final Actions: Governor signed on July 7, 2021
Effective Date:

HB21-1232 Standardized Health Benefit Plan Colorado Option

CRHC Positon: OPPOSE upon introduction, moved to MONITOR/NEUTRAL on 4/19/21.
CRHC Policy Priority Area: Mental & Behavioral Health
Final Actions: Senate Committee on Appropriations Postponed Indefinitely on 6/10/2020
CRHC Lobbying Activities: CRHC testified in Opposition of the bill to the House health committee. CRHC provided comments and authored letters to bill sponsors and attended stakeholder meetings and met with bill proponents, including the Governor's Office, the Division of Insurance and health committee members to provide member feedback as the legislation was developed.

HB21-1232	**HB21-1232 Standardized Health Benefit Plan Colorado Option STRIKEBELOW AMENDMENTS FROM 4/13**

***Full text of amendment language attached.**
Vote totals: Support (0) Oppose (1) Monitor (9) Neutral (0)
Amendment Summary:
Carrier requirements:

- Commissioner of Insurance will design a plan with input from stakeholders to be offered in the 2022 plan year in both the individual and small group market.
- There is a requirement that the stakeholder input include geographic diversity and include individuals impacted by higher rates of health disparities and inequities (AKA rural). The stakeholder process also includes physicians, healthcare industry representatives. Previous bill versions excluded health insurance carrier participation in the stakeholder process, but this version adds them.
- The plan will include all current essential health benefits as mandated by the ACA.
- The plan will include silver, bronze and gold levels of coverage.

- The plan will be offered through the exchange and through a public benefit corporation (a body created to administer and oversee the Colorado option).
- Network adequacy:
  - The plan must have a provider network that is no more narrow than the most restrictive network currently offered by the carrier.
  - Carriers will have to describe their efforts to construct networks that will address health equity and decrease disparities.
  - If a carrier is unable to do any of the above, the carrier will file an action plan with the DOI outlining their efforts to meet the requirements
  - Starting in 2024, the Commissioner will report to the General Assembly on the carrier's efforts. They must include non-aggregated data when reporting on this.
- Beginning in 2023, all carriers will be required to offer the standardized plan in every county that they offer other individual and small group plans.
- Also beginning in 2023, carriers that offer the standardized plan must make it available at a premium rate that is at least 6% less than 2021 plan year.
  - This 6% reduction will be adjusted for consumer price index (CPI) inflation
  - The 6% reduction will be calculated based on rates charged in the same county for individual and small group plans in 2021 prior to reinsurance.
  - For carriers offering the plan in 2023 in counties they didn't offer plans before, they must offered the standardized plan at 6% less than the average premium rate for the average individual premium rate for that county.
- Beginning in 2024, carriers that offer the standardized plan must make it available at a premium rate that is at least 12% less than 2021 plan year.
  - This 12% reduction will be adjusted for consumer price index (CPI) inflation
  - The 12% reduction will be calculated based on rates charged in the same county for individual and small group plans in 2021 prior to reinsurance.
- Beginning in 2025, carriers that offer the standardized plan must make it available at a premium rate that is at least 18% less than 2021 plan year.
  - This 18% reduction will be adjusted for consumer price index (CPI) inflation
  - The 18% reduction will be calculated based on rates charged in the same county for individual and small group plans in 2021 prior to reinsurance.
- Beginning in 2026 and each year after, each carrier and healthcare coverage cooperative must limit any annual premium increase to a rate no more than medical inflation.
  -

Rate filing disputes:

- If a carrier or provider is unable to meet the targeted premium reductions or the network adequacy requirements, a carrier or provider may initiate nonbinding arbitration.

- The carrier will notify the Commissioner by March 1 of each year prior to the targeted reductions that they are unable to meet the requirements. The must also include reasons why they were unable to do so.
- DOI will hold a public hearing prior to investigate why carriers are unable to meet the target. The hearing must take place before rates are approved on April 1 of each year.
- The hearing will be open to public testimony. All affected parties, including carriers, hospitals, providers, consumer advocates and individuals, will have the opportunity to present evidence regarding the carrier's ability to meet the targets and network adequacy requirements.
- The Office of Insurance Ombudsman Office, also created in the bill, will participate in the hearings and represent the consumers.
- Based on the evidence presented, the Commissioner may:
  - Establish rates reimbursement rates for hospitals or providers that will meet the premium targets.
  - **The reimbursement rate for hospitals shall not be less than 150% of Medicare. The base rate of 150% may be adjusted as follows:**
    - **Critical Access Hospitals or independent hospitals must receive an additional 20% increase**
    - **A CAH that is not a part of a health system must receive an additional 40% increase.**
    - **A hospital with a combined Medicaid/Medicare patient panel average that exceeds the statewide average must receive up to an additional 30% increase, with the actual increase based on the hospital's percentage share of Medicare/Medicaid.**
    - **A hospital that is efficient in managing the cost of care as determined by their total margins, operating costs and net patient revenue must receive up to an additional 40% increase.**
    - **This formula will allow for a maximum reimbursement rate of 280% of Medicare.**
  - Require hospitals AND providers accept the rates established.
  - Require carriers to offer the standardized plan in specific counties.
- A carrier or provider may appeal any of the Commissioner's decisions in district court.
- Healthcare cooperatives may be exempt from any of these requirements if they have achieved at least 18% premium reductions from whatever year they began offering plans.
- If the 1332 waiver is denied or suspended, DOI may adjust the premium reduction targets in the individual market to maximize subsidies.

Establishment of an Advisory Committee:

- The Commissioner will consult with an advisory committee when developing the methodology for evaluating the premium reductions.
- The Advisory Committee may include up to 11 members, including individuals who:
  - Have faced barriers to health access, including people of color, immigrants and low-income Coloradans
  - Have experience purchasing the standardized plan
  - Represent consumer advocacy groups
  - Have expertise in health equity
  - Have expertise in benefits for small businesses
  - Have experience with designing healthcare plans and setting rates
  - Represent hospitals or who have experience with contracts between hospitals and carriers
  - Represent healthcare providers who have experience with contracts between providers and carriers
  - Represent an employee organization that represents healthcare employees

1332 waiver

- Commissioner shall apply for a 1332 waiver from the feds
- If the waiver is granted, the Commissioner may use the federal funds for the administration of the Colorado Option.

Consumer Advocate Ombudsman Office

- As previously referenced, the Consumer Advocate Ombudsman Office will be created to advocate for consumers in regards to the Colorado Option plan and implementation
- The Ombudsman Office will:
  - Interact with consumers to gather their input
  - Evaluate data to assess the affordability and network adequacy requirements
  - Represent the interests of consumer in the public rate hearings
  - Act independently from the DOI. Any recommendations from the Ombudsman office will not constitute views of the DOI.

Hospital Participation

- Hospitals in the state will be required to accept the Colorado Option plan or face fines of up to $10,000/day for each day over 30 days that they refuse to participate
- After the 30 days and fines, the state may suspend, revoke or impose conditions on the hospital's license
- DOI shall consider the financial circumstances of the hospital when determining the appropriate penalties.

Provider Participation

- TBD on the fines/penalties for providers who refuse to accept the Colorado Option plan.