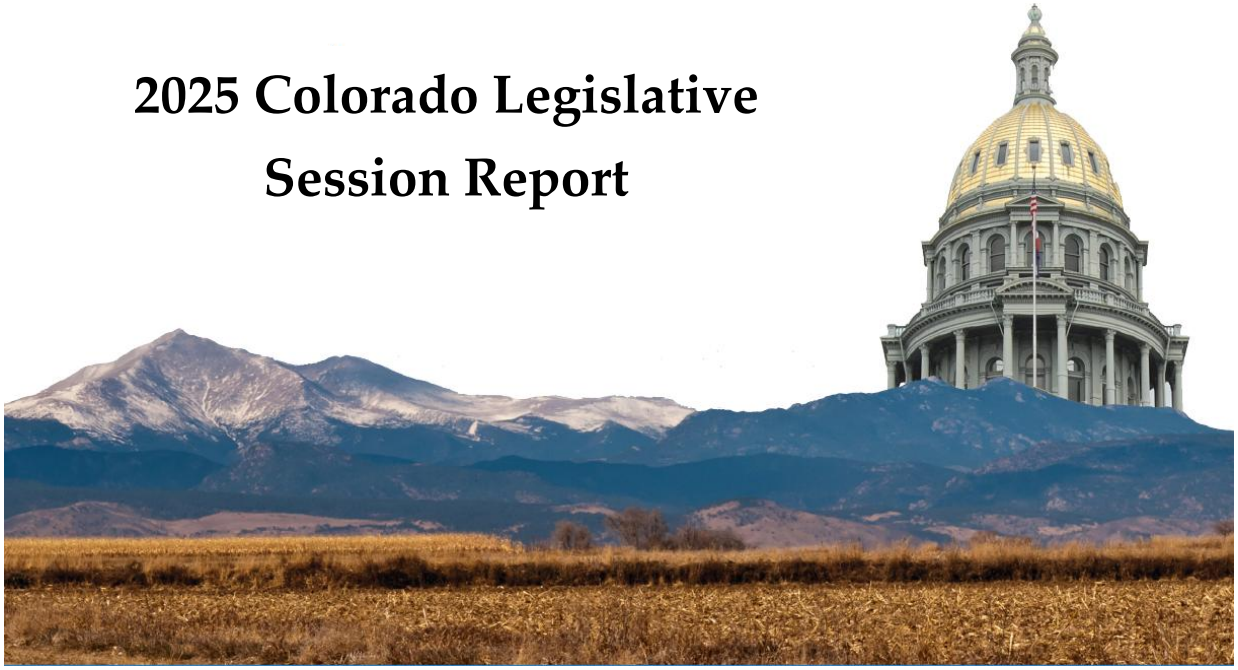
COLORADO RURAL HEALTH CENTER
The State Office of Rural Health

2025 Colorado Legislative Session Report



The 2025 Colorado legislative session was marked by a significant state budget shortfall, pushback to proposals from the federal Trump administration, and an historical battle between Colorado hospitals and the pharmaceutical industry. During the 120-day session, CRHC worked across party lines with a broad coalition of healthcare stakeholders to further our policy priorities by influencing and improving legislation and ensuring the unique perspectives of rural healthcare providers were heard under the gold dome. As a result of our hard work, we have many legislative wins and critical rural health updates with CRHC members we are excited to share.

By the numbers:

Six hundred and fifty-seven bills were introduced in 120 days, with 476 passing and signed by Governor Polis, who vetoed 11 bills, a personal record during his tenure as Governor. This 72% passage rate comparatively aligns with previous years, with 74% (523 bills) passing in 2024, and 78% (483 bills) passing in 2023.

CRHC took positions on 25 bills, including 14 support, 4 oppose, 6 monitor, 1 amend. **An exciting 93% of the bills CRHC supported passed!**

To achieve our desired bill outcomes and support our policy priorities, CRHC tracked 93 bills, hosted 12 PLC meetings amounting to almost 18 hours of member discussion, testified 10 times in committee, secured numerous bill amendments, and continued building countless relationships with Colorado policymakers, department representatives, and partner healthcare organizations. CRHC also co-hosted Hospitals & Rural Health Day on the Hill with our

partners at the Colorado Hospital Association, bringing together rural healthcare professionals from across the state to meet and interact with legislative leaders during a crucial time.

CRHC Priorities

Despite a challenging session, CRHC made great strides toward our policy priorities while also defending members from harmful policies.

Our top priority, **Reimbursement**, required a defensive position. HB25-1174 would have capped reimbursement rates for certain hospitals and used the savings to supplement the Primary Care Fund, a state fund primarily supporting Colorado's Federally Qualified Health Centers (FQHCs). The potentially disastrous bill would have strained Colorado's already fragile healthcare delivery system, and likely not made a timely impact to support FQHCs. CRHC partnered with the Save Our Safety Net Coalition (SOSN) to champion SB25-290, which leverages private contributions, state funds and federal matching funds to provide immediate support for primary care safety net providers impacted by the Medicaid unwind and subsequent sharp increase in uninsured patients.

CRHC also defended cuts to Medicaid, a threat early in the session to balance the state budget by cutting provider reimbursement rates. Not only did the legislature reject the cuts, but they approved a 1.6% provider rate increase and rejected a proposal to cut Medicaid reimbursement for Remote Patient Monitoring, slated to begin in July 2025.

Our second priority, **Healthcare Workforce**, saw a few marginal wins with the passage of HB25-1082 which broadens the providers who may certify death certificates to include advanced practice providers, and HB25-1016 which allows occupational therapists to prescribe durable medical equipment.

Healthcare Access, our third priority, took center stage this session and required both proactive and defensive advocacy with the battle around the 340B drug program. CRHC advocated for SB25-071, which protects the use of contract pharmacies for Colorado's 340B hospitals, ensuring patients have access to drugs when and where they need them. Conversely, CRHC advocated against SB25-124, a bill brought by the pharmaceutical industry that would have placed onerous reporting requirements on certain 340B entities. Both bills yielded lengthy committee hearings and floor debates, with SB25-124 eventually defeated.

Another significant win occurred with our fourth priority, **Administrative & Regulatory Burden**, with the passage of SB25-314 Recovery Audit Contractor (RAC) Program. With credit

to unmatched knowledge of the RAC program at the Colorado Hospital Association (CHA), SB25-314 significantly overhauls Colorado's onerous and punitive Medicaid RAC program, relieving rural healthcare providers from regulatory burden.

Finally, significant progress was made in our fifth priority, **Rural Health Investments & Sustainability**, despite state budget shortfalls. HB25-1223 will leverage philanthropic donations to conduct a state study on the capital needs of Colorado's aging rural healthcare facilities. HB25-1085 provides greater flexibility for Colorado's county-owned rural hospital boards. Finally, SB25-078, which facilities greater collaboration between Colorado's rural hospitals.

The work has not ended since the session concluded, and we will continue to advocate for our members on both the state and federal level. A huge thank you to the Policy & Legislative Committee (PLC) members and CRHC Board of Directors for their commitment to supporting our policy program.

The following provides bill summaries and implementation details on each of the 25 bills CRHC had positions on this session categorized by topic. See the key for details about color-coding and symbols.

Key:
Bill title colors: **CRHC Support**, **CRHC Oppose**, **CRHC Monitor**, **CRHC Amend**
✓ **Bill Passed** ✗ **Bill failed**

Rural Health

✓ **HB25-1085 Public Hospital Boards of Trustees** makes changes to public hospital boards of trustees by:

- Allowing appointed public officials to serve on public hospital boards
- Requiring public hospital boards to meet annually (instead of each January)
- Removing the requirement that a hospital board trustee must examine hospitals twice per month.
- Moving the deadline for hospital boards to certify to a board of county commissioners the amount that is necessary to maintain the hospital for the next year from October 1 to December 1.

Implementation date: August 6, 2025.

✓ **SB25-078 Nonprofit Hospitals Collaborative Agreements** adds private, non-profit hospitals with fewer than 50 beds to the list of facilities approved to enter into collaborative agreements.
Implementation date: August 6, 2025.

✓ **HB25-1223 Capital Needs of Rural and Frontier Hospitals** requires CDPHE to estimate the total cost needed to meet the capital development needs of Colorado rural and frontier hospitals. The work will be overseen by a task force whose members are appointed by the Governor and legislative leadership, including three representatives of a rural or frontier hospital, one architect, one contractor, one organization representative of hospitals, and one resident of rural or frontier CO.
Implementation date: Task force members will be appointed within 2 months of obtaining funding for the report. The report is due no later than 18 months after the first task force meeting.

Prescription Drug Access & Affordability

✓ **SB25-071 Prohibit Restrictions on 340B Drugs** prohibits pharmaceutical manufacturers and other related entities from imposing limitations or restrictions on covered hospitals, contract pharmacies, federally qualified health centers, or other facilities participating in the federal 340B Drug Pricing Program. Manufacturers also may not require covered entities or pharmacies to submit health information unless it is directly related to a claim under a federal health care program. Additionally, covered hospitals will be required to report the following information to HCPF:

- Annual 340B savings from participating in the program.
- Descriptions about how the savings are utilized.
- Market rate costs to acquire 340B drugs.
- Total operating costs related to providing charity care.

Implementation date: August 6, 2025. Reporting requirements will be a part of the annual Hospital Transparency Report and/or Hospital Community Benefit reporting to HCPF.

✗ **SB25-124 Reducing Costs of Health Care for Patients would have** required 340B drug discount savings be passed on to patients and required extensive and onerous reporting for 340B hospitals.

✓ **HB25-1222 Preserving Access to Rural Independent Pharmacies** prevents a pharmacy benefit manager (PBM) from blocking a rural independent pharmacy from using private couriers or delivery services to deliver prescription drugs to patients and requires a PBM to pay

a dispensing fee and reimburse a rural independent pharmacy at no less than the average acquisition cost for similar prescription drugs. The bill also lays the foundation for "flex pharmacies" in Colorado.
Implementation date: PBMs must begin paying a dispensing fee by Jan. 1, 2026. The rest of the bill takes effect on August 6, 2025.

Support for the Safety Net

✓ **SB25-290 Stabilization Payments for Safety Net Providers** create the Provider Stabilization Fund within HCPF to distribute provider stabilization payments to safety net providers who provide services to low-income, uninsured individuals on a sliding-fee schedule or at no cost. Eligible providers include both designated and non-designated rural health clinics. The payments will be issued to eligible safety net providers based on the proportion of low-income, uninsured individuals that the provider serves in comparison to the total number of low-income, uninsured individuals served by all eligible safety net providers. The bill creates an advisory board to oversee the fund, including a representative of Rural Health Clinics.
Implementation date: Upon signature of the bill, funds are expected to be administered summer or fall of 2025.

✓ **HB25-1288 Support for Federally Qualified Health Centers** permits an FQHC to establish a subsidiary company to provide additional fee-for-service services outside of the FQHC's Medicaid encounter rate. The bill also authorizes HCPF to accept monetary gifts from private and public sources for the Primacy Care Fund.
Implementation date: Upon signature of the bill.

✗ **HB25-1174 Reimbursement Requirements for Health Insurers** would have implemented rate-setting for reimbursement to some Colorado hospitals. The bill intended to leverage savings from reimbursement caps on rates to supplement the Primary Care Fund, which largely supports FQHCs in the state.

Healthcare Workforce

✓ **HB25-1016 Occupational Therapist Prescribe Medical Equipment** authorizes an occupational therapist to directly prescribe durable medical equipment (DME) to a patient

without requesting the prescription from a licensed physician. Prior to the bill, Colorado already allowed physical therapists to prescribe DME.
Implementation date: August 6, 2025.

✓ **HB25-1082 Qualified Individuals Death Certificates** allows physician assistants and advanced practice registered nurses to determine a cause of death and complete a certificate of death, expanding the allowable list that previously limited to coroners, medical examiners, forensic pathologists, physicians or Chief Medical Officer of the institution where the death occurred.
Implementation date: August 6, 2025.

✓ **SB25-166 Health-Care Workplace Violence Incentive Payments** implements several changes to reduce workplace violence in healthcare settings, including:

- Implementing a performance metric related to workplace violence to HQIP.
- Convening a stakeholder group to develop recommended metrics, determine whether any federal or private funds are available to assist hospitals in lowering the number of incidents of workplace violence, and develop legislative recommendations.
- Requiring HCPF to develop a report that assesses whether each hospital has adopted a formal policy to address workplace violence and submitted the reporting requirements to CDPHE for the next federal fiscal year.
- The bill exempts hospitals with fewer than 100 beds from the reporting requirements.

Implementation date: By September 1, 2025, HCPF will establish the performance metrics with stakeholder feedback, the group will report to the General Assembly by February 1, 2026. Workplace violence reporting requirements for hospitals with over 100 beds begin July 1, 2026.

✓ **HB25-1022 Qualified Medication Administration Personnel** updates the definition of "qualified medication administration personnel" (QMAP) to include an individual who has passed a competency evaluation administered by CDPHE before July 1, 2017. Health facilities may require QMAP renewal or additional training upon hire.
Implementation date: Upon signature of the bill.

✓ **SB25-083 Limitations on Restrictive Employment Agreements** allows an employer to utilize non-compete agreements that allows for the recovery of the following expenses from a physician, APRN or dentist employee:

- Relocation expenses paid by the employer on behalf of an individual.
- A signing bonus
- Recruiting expenses paid by the employer
- Marketing expenses paid by the employer to market an individual healthcare provider.

Implementation date: August 6, 2025.

Colorado Medicaid

✓ **HB25-1162 Eligibility Redetermination for Medicaid Members** makes several improvements to the Colorado Medicaid eligibility process, including:

- Extending the timeline for member reenrollment based on the financial eligibility from 1 to 3 years for a Medicaid member whose income is based solely on a fixed income source (i.e. Disability).
- Requiring HCPF to verify a member's eligibility for reenrollment based on income and need at the same time.
- Requiring HCPF to modify the questions asked to medical professionals when verifying and completing the documentation for a member's need for long-term services and supports.
- Prohibiting HCPF from requiring new documentation for a member who transitions from receiving services in an institutional setting to receiving services in a home- and community-based setting and vice versa.

Implementation date: August 6, 2025.

✓ **SB25-314 Recovery Audit Contractor Program** makes several changes to HCPF's recovery audit contractor (RAC) program, including:

- Limiting RAC audits to only review claims that are no more than 3 years past the date of the expiration of the timely filing period.
- Limiting the number of audits a provider may undergo each year to 3.
- Limiting the number of medical records that can be requested for a given audit.
- Facilitating a proactive mediation in the case HCPF identifies preliminary findings during the RAC audit and allowing a provider that received preliminary findings to request an exit conference in an effort to resolve the identified concerns, including participating in an informal reconsideration before filing a formal appeal regarding HCPF's findings during a RAC audit.

Implementation date: August 6, 2025.

✓ **SB25-229 Reimbursement for Community Health Workers** delays implementation of SB23-002, which required HCPF to cover services provided by community health workers, including health education, screening, and advocacy— to January 1, 2026

Implementation date: January 1, 2026.

Private Insurance Carriers

✗ **HB25-1088 Costs for Ground Ambulance Services** allows a political subdivision (a city, town, county, special district, or governmental emergency service provider) or contracted ambulance service to submit rates for ambulance services to DORA. Submitted rates must be calculated to offset service costs, approved by the political subdivision, and applied uniformly to all patients. Any rates exceeding 325% of Medicare reimbursement must be justified by a cost analysis report. The bill requires insurance carriers to reimburse out-of-network ambulance services at the rates submitted to DORA or, if rates are not submitted, the lesser of billed charges or 325% of Medicare reimbursement rates. Additionally, out-of-network ambulance services cannot bill covered individuals for unpaid balances, except for cost-sharing amounts. Lastly, the bill requires insurance carriers to apply payments towards a covered individual's in-network deductible and out-of-pocket maximum.
Implementation date: August 6, 2025.

✗ **HB25-1151 Arbitration of Health Insurance Claims** would have made changes to the arbitration requirements for out-of-network health insurance claims by requiring the arbitration process to include a batching process**,** which allows multiple claims to be considered jointly and under the same arbitration fee as part of one payment determination. The bill would have allowed "batching" ONLY for out-of-network Emergency services, which aligns with federal law that allows for batching under the same circumstances.

✗ **HB25-1226 Health Care Review Interim Committee Billing Study** would have required the Statewide Health Care Review Committee to produce a report on the committee's activities and recommendations to improve health care billing practices.

Behavioral Health

✓ **HB25-1176 Behavioral Health Treatment Stigma for Providers** makes changes to the physician licensure application submitted to DORA in an effort to reduce the stigma of seeking healthcare for behavioral health conditions. The bill requires the application not to require the disclosure of, or ask questions pertaining to, medical or health information that is not relevant to the applicant's ability to provide safe, competent, and ethical patient care at the time of renewal. The bill clarifies that registered medical professionals are not required to disclose past physical illnesses or conditions, behavioral or mental health disorders, or substance use disorders that no longer impact their ability to practice with reasonable skill and safety.

Implementation date: August 6, 2025.

✓ **SB25-042 Behavioral Health Crisis Response Recommendations** implements changes recommended by the Legislative Oversight Committee Concerning the Treatment of Persons with Behavioral Health Disorders in the Criminal and Juvenile Justice Systems, including:

- Requiring a facility to only discharge a person placed on an emergency mental health hold if the person no longer meets the criteria for an emergency mental health hold; except that a facility may transfer the person to another facility if the facility is unable to provide the appropriate medical care to the person.
- Requiring the BHA to convene a stakeholder group to identify existing resources and model programs that communities throughout Colorado utilize when responding to behavioral health crises.
- Requiring the BHA to annually submit a report to the General Assembly on the outcomes of involuntary commitments by region and include recommendations to improve outcomes.
- Requiring hospitals to provide information to the BHA about their medical and behavioral health capabilities, including ability to provide care for involuntary holds, SUD, long-term hospitalizations, detox, and intensive outpatient programs.
- Requiring the Colorado Department of Public Safety (DPS) to compile a list of the existing resources and model programs and make the resources and information about the model programs publicly available on DPS's website.

Implementation date: Stakeholder group report due no later than December 31, 2025.

✓ **HB25-1002 Medical Necessity Determination Insurance Coverage** aims to strengthen state parity laws regarding coverage for behavioral health services by clarifying covered services and adding more stringent criteria for determining necessity. The bill clarifies that the health benefits coverage for behavioral health and substance use disorders must be no less extensive than the coverage provided for any physical illness. The bill requires every state-regulated health benefit plan must provide coverage for medically necessary treatment of covered behavioral, mental health, and substance use disorder benefits, including the placement, including admission, continued stay, transfer, and discharge of a covered person. The bill also specifies criteria to be used for utilization review, service intensity, the level of care for covered persons, and provider reimbursement.

Implementation date: January 1, 2026.

Other Issues

✓ **SB25-276 Protect Civil Rights Immigration Status** prohibits public childcare centers, schools, local education providers, institutions of higher education, healthcare facilities, and their employees from collecting or providing personal identifying information to federal immigration enforcement authorities related to an enrolled child or student, medical patient, or an individual's family. Records may only be released for subpoenas, orders, or warrants issued by a federal judge, or with explicit consent. Additionally, these public entities may not grant federal authorities access to areas of the property that are not accessible to the public, unless the authority holds a federal warrant. Policies that align with these requirements must be adopted and made public. Eligible employees that willfully violate these provisions are subject to an injunction and are liable for civil penalties up to $50,000.

Implementation date: Policy must be established by July 1, 2025.

✗ **SB25-198 Transparency Transactions Medical Care Entities** would have made several changes to the current requirements for licensed hospitals to provide notice to the Attorney General when involved in certain types of transactions and also required providers to disclose financial relationships to referred patients.

Implementation date: Despite the failure of the bill, sponsors agreed to postpone indefinitely and engage in interim stakeholder meetings to develop antitrust legislation for the 2026 legislative session.