

RECOMMENDATIONS FOR 2006

HEALTH CARE TASK FORCE

**Report to the
Colorado General Assembly**

**Research Publication No. 542
January 2006**

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January 2006

To Members of the Sixty-fifth General Assembly:

Submitted herewith is the final report of the Health Care Task Force. This committee was created pursuant to Senate Bill 05-227. The purpose of the committee is to study a variety of health care issues over five years.

At its meeting on November 15, 2005, the Legislative Council reviewed the report of this committee. A motion to forward this report and the bills therein for consideration in the 2006 session was approved.

Respectfully Submitted,

/s/ Senator Joan Fitz-Gerald
Chairman

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http://www.state.co.us/gov_dir/leg_dir/lcsstaff/2005/05interim.htm

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HEALTH CARE TASK FORCE

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EXECUTIVE SUMMARY

Committee Charge

Pursuant to Section 10-16-221, C.R.S., the Health Care Task Force is charged with studying provider reimbursement issues, network adequacy, and other health care issues that affect health insurance in this state.¹ The task force consists of ten members appointed by House and Senate leadership. The task force must meet at least four times each year, and continues until July 1, 2010.

Committee Activities

The Health Care Task Force met four times during the 2005 interim. Each meeting focused on a specific topic, and a time for public testimony was provided at each hearing.

Pharmacy benefit managers (PBM). The first meeting was devoted to a discussion of the role of PBMs and whether they should be regulated by the state. PBMs contract with health plans to manage the plan's prescription drug coverage. The National Conference of State Legislatures provided a national perspective on how some state legislatures have regulated PBMs, and the Colorado Department of Regulatory Agencies (DORA) summarized a 2004 sunrise review that addressed the possible regulation of pharmacy benefit managers. The task force then heard testimony from the group that requested the sunrise review of the industry, companies that provide pharmacy benefit management services, pharmacist organizations, health plans, business, and consumers.

Issues affecting hospitals in Colorado. At the second meeting, the task force heard about various issues impacting hospitals. The task force discussed the funding of the state's trauma care system, hospital-acquired infection rate reporting, workforce shortage issues, how the consolidation of hospital systems and the move out of urban areas is impacting the cost of health care, and the definition and role of specialty hospitals and ambulatory surgical centers.

Telemedicine. The third meeting allowed an examination of the use of telemedicine in Colorado. The task force heard about current efforts in both home health care and correctional care to utilize technology to provide health services. DORA provided background of the regulatory environment surrounding telemedicine in Colorado. As a result of discussions at this meeting, the task force is recommending Bill B which addresses reimbursement for home health care using telemedicine, and Bill C which requires a report on the possible utilization of telemedicine to deliver health services to inmates.

¹Up until its repeal on July 1, 2004, the Health Care Task Force existed in Section 26-15-107, C.R.S.

Health care workforce shortage issues. The final meeting of the task force focused on the health care workforce shortage in Colorado and nationally. Testimony was provided by a variety of health care workers, including nurses, doctors, the University of Colorado School of Medicine, and a panel representing higher education. In addition, the task force heard about a study that had been recently conducted on nursing supply and demand issues, state and private efforts to address the shortage issues, and the creation of a database that will track work force information statewide.

Committee Recommendations

As a result of committee discussion and deliberation, the committee recommends three bills for consideration in the 2006 legislative session.

Bill A — Public Reporting of Hospital-Acquired Infections. The bill requires reporting of hospital-acquired infection rates for certain clinical procedures. The Colorado Department of Public Health and Environment must create an annual report comparing infection rates for each individual hospital in the state, discussing findings, making conclusions, and spotting trends.

Bill B — Provision of Home Health Care Services Through the Use of Telemedicine under the Colorado Medical Assistance Program. The bill requires the Colorado Department of Health Care Policy and Financing to seek the necessary federal authorization for the reimbursement and provision of home health care services by certified home health care agencies using telemedicine.

Bill C — Department of Corrections Report Regarding the Provision of Medical Services to State Inmates Through the Use of Telemedicine. The bill requires the Colorado Department of Corrections to study and report on the state's options for providing medical services to state inmates in correctional facilities through the use of telemedicine. The report must be presented to the House and Senate Health and Human Services committees by February 1, 2007.

STATUTORY AUTHORITY AND RESPONSIBILITIES

Pursuant to Section 10-16-221, C.R.S., the Health Care Task Force must consider a variety of issues between July 1, 2005, and July 1, 2010, that include, but are not limited to:

- health care issues that may affect health insurance;
- emerging trends in Colorado health care and their impacts on consumers, including, but not limited to:
 - changes in relationships among health care providers, patients, and payors;
 - restrictions in health care options available to consumers;
 - professional liability issues arising from such restrictions;
 - medical and patient record confidentiality;
 - health care work force requirements; and
 - home care in the continuum of care;
- the ability of consumers to obtain and keep adequate, affordable health insurance coverage, including coverage for catastrophic illnesses;
- the effect of managed care on the ability of consumers to obtain timely access to quality care;
- the effect of recent shifts in the way health care is delivered and paid for;
- the operation of the program for the medically indigent in order to give guidance and direction to the Department of Health Care Policy and Financing in the development and operation of such program;
- future trends for health care coverage rates for employees and employers;
- costs and benefits of providing preventive care and early treatment for people with chronic illnesses who may eventually need long-term care;
- rural health care issues;
- options for addressing needs of the uninsured population;
- network adequacy and the adequacy of access to providers;
- reimbursement processes for health care services by third-party payors and cooperation between providers and carriers;
- certificates of need; and
- increased access to health care through the use of appropriate communication technologies, including the use of telemedicine.²

²Senate Bill 05-227 set forth the charge of the task force; however, Senate Bill 05-244 added the consideration of communication technologies, including telemedicine to the charge of the Health Care Task Force.

COMMITTEE ACTIVITIES

During the 2005 interim, the Health Care Task Force examined a variety of issues over the course of four meetings. Topics included a review of the utilization and possible need for regulation of pharmacy benefit managers, an examination of issues impacting hospitals in Colorado, an overview of the state's current utilization of telemedicine in home health care and in correctional care, and a discussion of the health care work force shortage in Colorado and nationally.

Background

The Health Care Task Force previously existed in Section 26-15-107, C.R.S., and met for five years, but it was repealed on July 1, 2004. The General Assembly, through the passage of Senate Bill 05-227, re-created the task force in Section 10-16-221, C.R.S. The task force will be in existence until 2010.

The task force charge includes an extensive array of health care issues. In 2005, the task force examined four separate areas.

Pharmacy Benefits Managers

Overview. The task force reviewed the current utilization of pharmacy benefit managers (PBMs) and discussed the associated state regulations. PBMs contract with health plans to manage the plans' prescription drug coverage. They receive payment for their services, typically perform some management functions such as claims adjudication, and may retain a portion of negotiated rebates secured from drug manufacturers. A recent study estimated that 68 percent of all prescriptions written in the United States are processed by a PBM.

PBM legislation in Colorado. Neither Colorado nor federal law directly regulate PBMs. In Colorado, some of the functions of PBMs are addressed in existing law. For example, under Colorado law, a mail-order pharmacy that mails prescription medications to a Colorado consumer must be properly registered as a nonresident pharmacy with the State Board of Pharmacy. In addition, to the extent that a PBM offers disease management services, such services may fall within the jurisdiction of the Colorado State Board of Medical Examiners. Finally, to the extent that a PBM has a contractual relationship with a Colorado-licensed health insurance carrier, various aspects of insurance law apply to PBMs, including network adequacy, uniform disclosures, prompt payment of claims, and procedures for appealing the denial of benefits. There have been two previous attempts to further regulate PBMs in Colorado. Both attempts failed. A description of both failed bills follows.

- Senate Bill 03-142 would have required the State Board of Pharmacy to regulate the activities of PBMs. While the bill contained numerous provisions to protect pharmacies and pharmacists, it also required PBMs to disclose to the board, pharmacies, insurance carriers, and consumers the rebates that PBMs obtain from drug manufacturers. Senate Bill 03-142 was postponed indefinitely by the Senate Appropriations Committee.
- House Bill 05-1300 stated that a PBM owes a fiduciary duty to a covered entity and outlined certain responsibilities for PBMs. Failure to comply with the provisions of the bill would have been a violation of the "Colorado Consumer Protection Act," and the Attorney General would have been able to seek injunctive relief and fines for violations. House Bill 05-1300 was postponed indefinitely by the House Health and Human Services Committee.

PBM legislation in other states. The National Conference of State Legislatures testified that as of June 2005, Georgia, Maine, Maryland, North Dakota, South Dakota, Vermont, and the District of Columbia have enacted some type of state PBM regulation. Regulation in these states varies, but includes:

- requiring PBMs to be licensed;
- requiring PBMs to register;
- requiring full disclosure of contracted activities between a PBM and pharmaceutical companies;
- requiring disclosure and transparency of the PBMs activities;
- allowing state examination of PBM contracts; and
- imposing a fiduciary duty on the PBM to the benefit of the PBMs client.

2004 sunrise review of PBMs by the Colorado Department of Regulatory Agencies. Rx Plus, an association of independent pharmacies, submitted a sunrise application to the Department of Regulatory Agencies (DORA) for review of state certification of PBMs. DORA completed this review in October 2004 and recommended against the regulation of PBMs for the following reasons:

- **Public harm.** The review found that when discussing PBMs, how harm is measured is critical to determining whether harm occurs. Consumers may suffer several types of easily recognizable harm as the result of PBM actions, such as physical harm from drug switching, higher prescription drug costs, and not receiving drugs from mail-order pharmacies. Other forms of harm could include higher overall health care costs, loss of or reduction in health care coverage, and higher costs for non-prescription products purchased at pharmacies. However, DORA found that regardless of how harm is measured, the applicant did not produce any specific instances of harm suffered by Coloradans. Rather, the applicant provided anecdotal evidence that could not be confirmed.

- **Need for regulation.** While the applicant claimed that regulation of PBMs is warranted because PBMs are the only part of the health care industry that is not regulated, DORA concluded otherwise. As part of the sunrise review, representatives of various PBM clients, including self-insured employers and health insurance carriers, were interviewed and each opposed regulation of PBMs. They maintained that their contracts with PBMs provide sufficient protection for themselves and their enrollees. In addition, DORA cited vigorous competition in the industry resulting in free market forces encouraging greater transparency without regulation.
- **Alternatives to regulation.** DORA found that alternatives to regulation appear to already be in place to some extent. All clients have contracts with their PBMs, upon which they can sue on appropriate grounds. While PBMs may not hold a fiduciary duty to anyone, PBM clients often do hold such duties to the benefit of their enrollees. So, according to DORA's review, the consumer is protected. The review found that one viable alternative to regulation would be to impose an ERISA-like fiduciary duty on all ERISA-exempt PBMs in favor of patients. Such a provision could be inserted into the Colorado Consumer Protection Act so that the Attorney General's Office could receive and act on complaints.

Committee recommendation. The committee did not recommend legislation in this area.

Hospital-Related Issues

At the second meeting, members heard about a variety of issues relating to hospitals including: Medicaid and Medicare reimbursement levels and the issue of cost shifting; an overview of the state's trauma system; statistics on hospital acquired infections; detail about hospital systems; and the role and function of specialty hospitals and surgical centers. The task force also briefly touched on the nursing shortage problem and decided to dedicate the fourth meeting to this issue, noting that it is a large problem in Colorado.

Medicaid and Medicare reimbursement levels and cost shifting. When patients do not have health insurance or their health insurance does not pay for all the care they need, the cost of their care is shifted to those patients with health insurance in the form of higher premiums, deductibles, and co-payments. The task force heard from hospitals stating that they are at the point now where they cannot shift any more of their costs to private insurance. The Children's Hospital stated it charges about a dollar to commercial insurers for every fifty cents in cost to make up for Medicaid shortfalls.

Colorado's trauma system. Trauma providers discussed the problems they are experiencing since the switch from no-fault to tort automobile insurance. Because claims take longer to settle, trauma providers have to wait longer for reimbursement. The Trauma Care Preservation Coalition cautioned that this could lead to reductions or cuts in trauma

services. The providers noted that they feel the impact even more than hospitals since they are not able to cost shift in order to make up the difference.

Hospital-acquired infections. Hospital-acquired infections are infections acquired in a hospital by a patient who was admitted for a reason other than that infection. These kinds of infections include those acquired in the hospital but appearing after discharge, and occupational infections among staff of the facility. There is no requirement either in Colorado nor at the national level to report these types of infections, although House Bill 05-1128 was introduced in the 2005 session to address this issue.

Representatives of the Association for Professionals in Infection Control and Epidemiology (APIC) discussed the extent of the problem. APIC is leading the effort for mandatory reporting of hospital-acquired infection rates by hospitals. The mandatory infection rates would be verified, analyzed, and disclosed to the public. Mandatory reporting would give consumers information they can use to make informed health care choices and would encourage hospitals to improve infection practices. Mandatory reporting may also cause hospital infection rates to decline, thus saving health care dollars related to patient readmissions and lengthy hospital stays.

Hospital consolidation. The task force received a report prepared for Colorado for Health Care, a project of the Service Employees International Union (SEIU), indicating that the consolidation of hospital systems in Denver have driven up health care costs. Hospital consolidation is when two or more hospitals are owned by the same company. At present, 75 percent of hospital beds in Denver are owned by one of the three hospitals systems. The report found that with hospital consolidation comes efficiency in health care delivery and lower expenses. However, the project spokesperson stated that hospital consolidation does not improve patient care and has been linked with a rise in health care costs for patients due to the tremendous amount of market control it gives hospitals. Denver went from a fairly wide and diverse group of community hospitals into essentially one public system and three private systems: HCA-HealthOne, Centura, and Exempla.

The role and function of specialty hospitals and ambulatory surgical centers. The committee heard about the role of specialty hospitals, surgery centers, and convalescent care facilities. Surgery centers handle low-cost procedures that are not life threatening, where there is low blood loss, and where the patient's total stay is 23 hours or less. Convalescent care centers are where low-intensity patients recover after surgery. Some testimony indicated that specialty hospitals can choose surgeries with high profit margins and minimal hospital stays. And, since they have the ability to chose the types of patients they serve — usually patients with private insurance — this pulls profitable, low-risk surgeries away from general hospitals, thus leaving them with the Medicaid, costly, and long-term care patients.

Committee recommendations. The task force considered a bill that addressed trauma care funding, but did not recommend that this bill be forwarded acknowledging that the Interim Committee on Auto Insurance was proposing a very similar bill. The task force

did recommend Bill A which requires hospitals to report the incidence of hospital-acquired infections.

Telemedicine

Overview. Telemedicine is the use of advanced telecommunication and information technologies to exchange health information and to provide health care services across geographic, time, social, and cultural barriers. Some of the *benefits* of telemedicine are:

- ✓ decreased travel for patients, providers, and staff;
- ✓ increased access to specialty consults and second opinions;
- ✓ decreased information processing time;
- ✓ increased efficiency of care; and
- ✓ lowered costs of patient care.

Some of the *challenges* related to telemedicine include:

- ✓ lack of a robust rural infrastructure;
- ✓ insurance reimbursement policies;
- ✓ establishment of industry standards; and
- ✓ security, equipment, maintenance, and transmission costs.

In addition, some uses of telemedicine may actually reduce rural access to health care if revenue is removed from the local community.

Under current Colorado law, the practice of medicine occurs where the patient is located; thus, physicians who practice medicine in Colorado by means of telemedicine must have a valid Colorado medical license. The task force received testimony from numerous parties describing the varied uses of telemedicine.

Telemedicine and home care. Based on testimony presented to the task force, home care is one area where studies and pilot programs have shown telemedicine to be a tool for improving health outcomes. Testimony was provided regarding a "Centura Health at Home" project involving 15 acutely-ill, congestive heart failure patients with histories of high hospitalization and emergency room visits. Results from the year-long program included a 100 percent drop in emergency room visits, a 90 percent reduction in hospitalizations, and high patient satisfaction. Centura estimated the cost to be about \$400 per month for the sickest, most expensive patients, which is a significant savings over the cost of hospitalization or visits to the emergency room. They emphasized that no reimbursement model currently exists through Medicare or Medicaid for these services.

Telemedicine and correctional care. The task force learned that there are currently about 2 million inmates in U.S. jails and prisons with approximately \$3.3 billion annually spent on health care costs. Locally, Denver Health contracts with all Denver metro counties, the Colorado Department of Corrections, and the U.S. Marshals to provide health services to inmates. Denver Health conducts about 120 visits a year using telemedicine.

Telemedicine in other states. Representatives from the Pediatrix Medical Group discussed the Pediatrix outreach program in cooperation with the Arizona Telemedicine Program. Pediatrix is a nationwide physician organization focusing on high risk obstetrics. The Arizona Telemedicine Program started in 1979, and in 1996, the Arizona legislature appropriated \$1.2 million to fund the start-up of the Arizona Rural Telemedicine Network. Today, the program has over 160 sites used by over 50 health care organizations, and it has served over 150,000 patients. Ongoing funding is from state, federal, and private sources. The Pediatrix spokesperson stated that the State of Arizona has saved millions of dollars annually through reduced or avoided emergency transports, behavioral medicine admissions, patient travel and per diem, and inpatient admissions. In addition, telemedicine allows for more intensive follow-up care resulting in improved patient compliance with disease management. The Pediatrix spokesperson added that Arizona's Department of Corrections has used over 8,000 telemedicine visits since it began, saving over \$1 million in travel and admissions costs.

Committee recommendations. The task force recommends Bill B which requires the Department of Health Care Policy and Financing to seek federal authorization for the reimbursement and provision of home health care services via telemedicine. In addition, after hearing testimony about significant savings from the use of telemedicine in correctional care in Arizona, the task force recommends Bill C. This bill requires the Department of Corrections to study and report on the state's options for using telemedicine to provide medical services to state inmates.

Health Care Workforce Shortages

The final meeting focused on the health care work force shortages in Colorado and nationally. The task force heard that significant shortages exist in the health care arena in all parts of the state, and that these shortages are projected to grow over the next 15 years, especially in nursing. Causes of this shortage include an aging population that will increase the demand over the coming decade, and also a large number of providers reaching retirement age that will cause the supply to decline unless more recruits can be trained. The task force also heard from the higher education community related to the number of nursing programs and the capacity of those programs. A variety of recruitment and retention efforts in the health care arena were discussed.

The task force received a report on a study of nursing faculty supply and demand that was conducted in 2004 by the Colorado Center for Nursing Excellence and the Colorado Health Institute.³ The study estimated that there is currently an 11 percent shortage of nurses in Colorado, which is two times greater than the national average. Without a significant increase in the training of new nurses, this shortage is projected to triple to 30 percent by 2020 according to the study. According to the study, during this same period, the population of Colorado is expected to increase by 16 percent, while the population aged 65 and older is projected to grow 113 percent.

In addition, the task force heard about state efforts to increase the number of trained health care professionals across the state.

³Available on-line at: <http://www.coloradonursingcenter.org/>

SUMMARY OF RECOMMENDATIONS

As a result of the committee's activities, three bills are recommended to the Colorado General Assembly.

Bill A — Concerning the Public Reporting of Hospital-Acquired Infections

Bill A requires a hospital to collect data on hospital-acquired infection rates for specified clinical procedures and to regularly submit its hospital-acquired infection data to the National Healthcare Safety Network within the Centers for Disease Control and Prevention beginning on or before September 30, 2007. This bill is similar to a bill that was introduced in the 2005 session and is an attempt to comply with upcoming federal data reporting requirements that will require all licensed hospitals in the United States to report their infection rates.

The bill creates an 11-member advisory committee consisting of a representative of a public hospital, a representative of a private hospital, a physician, four infection control practitioners, a medical statistician or clinical microbiologist, a representative of a health consumer organization, a health insurer, and a purchaser of health insurance. The advisory committee will assist the Department of Public Health and Environment in developing the methods of collecting, analyzing, and disclosing information collected, including collection methods, formatting, and methods and means for release and dissemination. The department must submit an annual report summarizing and analyzing the data from the hospitals to the Health and Human Services Committees of the General Assembly beginning in 2008.

The department must create an annual report which compares infection rates for each individual hospital in the state, discusses findings, makes conclusions, and spots trends. Patient confidentiality must be maintained during the reporting. All information and materials obtained and compiled by the department will remain confidential and not subject to disclosure. Failure to comply with the reporting requirement may result in termination of a hospital's license, or a fine of up to \$1,000 per violation per day.

Bill A is assessed as having a state fiscal impact as the Department of Public Health and Environment will incur costs through providing direction for the reporting process; working with hospitals regarding Colorado specific analyses; and providing technical assistance and follow-up on incomplete or missing reports. This will be done on an ongoing basis to the hospitals, ambulatory surgical centers and dialysis treatment clinics that will be required to report infection rates. In addition, the department must prepare and submit the annual report based on the infection rate data and answer questions as well as provide public information. Further, although the advisory committee members are required to serve without compensation, it is assumed that the members will be reimbursed for actual and necessary expenses to attend meetings.

Bill B — Concerning the Provision of Health Care Services Through the Use of Telemedicine under the Colorado Medical Assistance Program

The task force was directed to examine the use of telemedicine with the goal of containing or lowering health care costs. Bill B helps set up telemedicine in areas of the state where accessibility is a problem. The bill requires the Department of Health Care Policy and Financing to seek the necessary federal authorization for the reimbursement and provision of home health care services by certified home health care agencies using telemedicine. The goal is to keep more people in their homes rather than transferring them to assisted living and nursing homes. Since the bill does not require the department to implement the provision of home health care services through telemedicine, it is assessed as having no fiscal impact.

Bill C — Concerning the Department of Corrections Report Regarding the Provision of Medical Services to State Inmates Through the Use of Telemedicine

The task force learned that some correctional facilities have health facilities on-site while others do not. The cost of transporting inmates to health facilities is costly, therefore the task force opted to require the Department of Corrections to study how much it would cost to provide more services through the use of telemedicine. Bill C requires the Department of Corrections to study and report on the state's options for providing medical services to state inmates in correctional facilities through the use of telemedicine. The report must be presented to the House and Senate Health and Human Services Committees by February 1, 2007, and must address, at a minimum:

- the technology available to provide medical services to state inmates through the use of telemedicine;
- the technological and training needed to provide medical services to state inmates through telemedicine, and the estimated cost of meeting those needs;
- the estimated cost savings associated with providing medical services to state inmates using telemedicine. The department must consider other states' experiences when calculating the cost savings associated with telemedicine; and
- the estimated impact on local economies if the department implements telemedicine to provide medical services to state inmates.

The bill is assessed as having a state fiscal impact as the department will need to contract with a medical consulting firm to conduct this study.

RESOURCE MATERIALS

The resource materials listed below were provided to the committee or developed by Legislative Council Staff during the course of the meetings. The summaries of meetings and attachments are available at the Division of Archives, 1313 Sherman Street, Denver, (303- 866-2055). The meeting summaries and materials developed by Legislative Council Staff are also available on our web site at:

www.state.co.us/gov_dir/leg_dir/lcsstaff/2005/05interim.htm.

<u>Meeting Summaries</u>	<u>Topics Discussed</u>
August 3, 2005	Pharmacy Benefit Managers: The National Conference of State Legislatures provided an overview of what states are doing regarding the regulation of PBMs. The Department of Regulatory Agencies summarized a 2004 sunrise report that was prepared in response to a request for the regulation of PBMs, and the group who requested the sunrise review provided detail about why it feels this regulation is needed. The task force then heard from companies that provide pharmacy benefit management services, health plans, businesses, and consumer organizations.
September 1, 2005	Hospital Issues: The task force heard about a variety of issues impacting hospitals including reimbursement rates, factors driving hospital costs, work force shortages, length of stay, infection rates, the impact of consolidating hospital systems, the role and function of specialty hospitals and surgical centers.
September 27, 2005	Telemedicine: The task force heard about telehealth and telemedicine efforts in Colorado. Specifically, representatives of rural efforts, Denver Health, and home care providers spoke about the need and cost-effectiveness of expanding telemedicine in the state.

October 13, 2005

Health Care Workforce Shortages: Organizations representing various health care providers discussed the extent of the work force shortages in the health arena. The State Work Force Development Council discussed several efforts that are currently being implemented to address shortages in the health care fields. The Task force also received a briefing from representatives of higher education related to the need for collaboration between hospitals and higher education in providing qualified staff and expanding the number of students who can be served.

Legislative Council Staff Memoranda:

July 27, 2005, *Overview of the Health Care Task Force*

July 27, 2005, *Pharmacy Benefit Managers*

September 20, 2005, *Current Colorado law Addressing Telemedicine*

Second Regular Session
Sixty-fifth General Assembly
STATE OF COLORADO

Bill A

DRAFT

LLS NO. 06-0128.01 Michael Dohr

HOUSE BILL

HOUSE SPONSORSHIP

McCluskey, Butcher, Frangas, and Todd

SENATE SPONSORSHIP

Keller, Gordon, and Tochtrop

House Committees

Senate Committees

A BILL FOR AN ACT

101 CONCERNING PUBLIC REPORTING OF HOSPITAL-ACQUIRED INFECTIONS.

Bill Summary

(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments that may be subsequently adopted.)

Health Care Task Force. Requires a hospital to collect data on hospital-acquired infection rates for specified clinical procedures and to routinely submit its hospital-acquired infection data to the national healthcare safety network in accordance with national healthcare safety network requirements and procedures. Creates an advisory committee to assist the department of public health and environment ("department") in the development of all aspects of the department's methodology for collecting, analyzing, and disclosing information collected, including collection methods, formatting, and methods and means for release and

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.
Capital letters indicate new material to be added to existing statute.
Dashes through the words indicate deletions from existing statute.

1 ANTIGEN-ANTIBODY REACTION IN THE HOST.

2 **25-3-602. Hospital reports.** (1) (a) A HOSPITAL SHALL COLLECT
3 DATA ON HOSPITAL-ACQUIRED INFECTION RATES FOR SPECIFIC CLINICAL
4 PROCEDURES, INCLUDING THE FOLLOWING CATEGORIES:

5 (I) CARDIAC SURGICAL SITE INFECTIONS;

6 (II) ORTHOPEDIC SURGICAL SITE INFECTIONS; AND

7 (III) CENTRAL LINE-RELATED BLOODSTREAM INFECTIONS.

8 (b) THE ADVISORY COMMITTEE MAY DEFINE CRITERIA TO
9 DETERMINE WHEN DATA ON A PROCEDURE LISTED IN PARAGRAPH (a) OF
10 THIS SUBSECTION (1) SHALL BE COLLECTED.

11 (c) INDIVIDUALS WHO COLLECT THE DATA ON HOSPITAL-ACQUIRED
12 INFECTIONS RATES FOR A HOSPITAL SHALL HAVE APPROPRIATE NATIONAL
13 CERTIFICATION FOR HOSPITAL DATA COLLECTION ON OR BEFORE
14 SEPTEMBER 30, 2007.

15 (2) EACH PHYSICIAN WHO PERFORMS A CLINICAL PROCEDURE
16 LISTED IN SUBSECTION (1) OF THIS SECTION SHALL REPORT TO THE
17 HOSPITAL AT WHICH THE CLINICAL PROCEDURE WAS PERFORMED A
18 HOSPITAL-ACQUIRED INFECTION THAT THE PHYSICIAN DIAGNOSES AT A
19 FOLLOW-UP APPOINTMENT WITH THE PATIENT USING STANDARDIZED
20 CRITERIA AND METHODS CONSISTENT WITH GUIDELINES DETERMINED BY
21 THE ADVISORY COMMITTEE. THE REPORTS MADE TO THE HOSPITAL UNDER
22 THIS SUBSECTION (2) SHALL BE INCLUDED IN THE REPORTING THE HOSPITAL
23 MAKES UNDER SUBSECTION (3) OF THIS SECTION.

24 (3) (a) A HOSPITAL SHALL ROUTINELY SUBMIT ITS
25 HOSPITAL-ACQUIRED INFECTION DATA TO THE NATIONAL HEALTHCARE
26 SAFETY NETWORK IN ACCORDANCE WITH NATIONAL HEALTHCARE SAFETY
27 NETWORK REQUIREMENTS AND PROCEDURES. THE DATA SUBMISSIONS

1 SHALL BEGIN ON OR BEFORE SEPTEMBER 30, 2007, AND CONTINUE
2 THEREAFTER.

3 (b) IF A HOSPITAL IS A DIVISION OR SUBSIDIARY OF ANOTHER
4 ENTITY THAT OWNS OR OPERATES OTHER HOSPITALS OR RELATED
5 ORGANIZATIONS, THE DATA SUBMISSIONS REQUIRED UNDER THIS PART 6
6 SHALL BE FOR THE SPECIFIC DIVISION OR SUBSIDIARY AND NOT FOR THE
7 OTHER ENTITY.

8 (c) HOSPITALS SHALL AUTHORIZE THE DEPARTMENT TO HAVE
9 ACCESS TO HOSPITAL-SPECIFIC DATA CONTAINED IN THE NATIONAL
10 HEALTHCARE SAFETY NETWORK DATABASE CONSISTENT WITH THE
11 REQUIREMENTS OF THIS PART 6.

12 (4) (a) THE EXECUTIVE DIRECTOR OF THE DEPARTMENT SHALL
13 APPOINT AN ADVISORY COMMITTEE. THE ADVISORY COMMITTEE SHALL
14 CONSIST OF:

- 15 (I) ONE REPRESENTATIVE FROM A PUBLIC HOSPITAL;
- 16 (II) ONE REPRESENTATIVE FROM A PRIVATE HOSPITAL;
- 17 (III) ONE BOARD-CERTIFIED OR BOARD-ELIGIBLE PHYSICIAN
18 LICENSED IN THE STATE OF COLORADO, WHO IS AFFILIATED WITH A
19 COLORADO HOSPITAL OR MEDICAL SCHOOL, WHO IS AN ACTIVE MEMBER
20 OF A NATIONAL ORGANIZATION SPECIALIZING IN HEALTH CARE
21 EPIDEMIOLOGY OR INFECTION CONTROL, AND WHO HAS DEMONSTRATED
22 AN INTEREST AND EXPERTISE IN HEALTH FACILITY INFECTION CONTROL;
- 23 (IV) FOUR INFECTION CONTROL PRACTITIONERS, THREE OF WHOM
24 ARE REGISTERED NURSES, CERTIFIED BY THE CERTIFICATION BOARD OF
25 INFECTION CONTROL AND EPIDEMIOLOGY;
- 26 (V) EITHER ONE MEDICAL STATISTICIAN WITH AN ADVANCED
27 DEGREE IN SUCH SPECIALTY OR ONE CLINICAL MICROBIOLOGIST WITH AN

1 ADVANCED DEGREE IN SUCH SPECIALTY;

2 (VI) ONE REPRESENTATIVE FROM A HEALTH CONSUMER
3 ORGANIZATION;

4 (VII) ONE REPRESENTATIVE FROM A HEALTH INSURER; AND

5 (VIII) ONE REPRESENTATIVE FROM A PURCHASER OF HEALTH
6 INSURANCE.

7 (b) THE ADVISORY COMMITTEE SHALL ASSIST THE DEPARTMENT IN
8 DEVELOPMENT OF ALL ASPECTS OF THE DEPARTMENT'S METHODOLOGY FOR
9 COLLECTING, ANALYZING, AND DISCLOSING THE INFORMATION COLLECTED
10 UNDER THIS PART 6, INCLUDING COLLECTION METHODS, FORMATTING,
11 TYPES OF CASES, AND METHODS AND MEANS FOR RELEASE AND
12 DISSEMINATION.

13 (c) THE DATA COLLECTION AND ANALYSIS METHODOLOGY SHALL
14 BE DISCLOSED TO THE PUBLIC PRIOR TO ANY PUBLIC DISCLOSURE OF
15 HOSPITAL-ACQUIRED INFECTION RATES.

16 (d) THE DEPARTMENT AND THE ADVISORY COMMITTEE SHALL
17 EVALUATE ON A REGULAR BASIS THE QUALITY AND ACCURACY OF
18 HOSPITAL INFORMATION REPORTED UNDER THIS PART 6 AND THE DATA
19 COLLECTION, ANALYSIS, AND DISSEMINATION METHODOLOGIES.

20 (e) THE ADVISORY COMMITTEE SHALL ELECT A CHAIR OF THE
21 ADVISORY COMMITTEE ANNUALLY. THE ADVISORY COMMITTEE SHALL
22 MEET NO LESS THAN FOUR TIMES PER YEAR IN ITS FIRST YEAR OF
23 EXISTENCE AND NO LESS THAN TWO TIMES IN EACH SUBSEQUENT YEAR.
24 THE CHAIR SHALL SET THE MEETING DATES AND TIMES. THE MEMBERS OF
25 THE ADVISORY COMMITTEE SHALL SERVE WITHOUT COMPENSATION.

26 (5) (a) THE ADVISORY COMMITTEE SHALL RECOMMEND
27 ADDITIONAL CLINICAL PROCEDURES BASED UPON THE CRITERIA SET FORTH

1 IN PARAGRAPH (c) OF THIS SUBSECTION (5) THAT MUST BE REPORTED
2 PURSUANT TO SUBSECTION (1) OF THIS SECTION IN THE MANNER SPECIFIED
3 IN PARAGRAPH (b) OF THIS SUBSECTION (5). THE RECOMMENDATIONS OF
4 THE ADVISORY COMMITTEE SHALL BE CONSISTENT WITH INFORMATION
5 THAT MAY BE COLLECTED BY THE NATIONAL HEALTHCARE SAFETY
6 NETWORK.

7 (b) (I) ON OR BEFORE NOVEMBER 1, 2008, THE ADVISORY
8 COMMITTEE SHALL EITHER RECOMMEND TO THE DEPARTMENT THE
9 ADDITION OF AT LEAST TWO CLINICAL PROCEDURES TO THE DATA
10 COLLECTED ON HOSPITAL-ACQUIRED INFECTION RATES AS REQUIRED IN
11 THIS SECTION OR COMPLY WITH THE PROVISIONS OF PARAGRAPH (d) OF
12 THIS SUBSECTION (5).

13 (II) IN ADDITION TO THE REQUIREMENTS OF SUBPARAGRAPH (I) OF
14 THIS PARAGRAPH (b), ON OR BEFORE NOVEMBER 1, 2010, THE ADVISORY
15 COMMITTEE SHALL EITHER RECOMMEND TO THE DEPARTMENT THE
16 ADDITION OF AT LEAST TWO CLINICAL PROCEDURES TO THE DATA
17 COLLECTED ON HOSPITAL-ACQUIRED INFECTION RATES AS REQUIRED IN
18 THIS SECTION OR COMPLY WITH THE PROVISIONS OF PARAGRAPH (d) OF
19 THIS SUBSECTION (5).

20 (c) IN MAKING ITS RECOMMENDATIONS UNDER PARAGRAPH (a) OR
21 (b) OF THIS SUBSECTION (5), THE ADVISORY COMMITTEE SHALL
22 RECOMMEND CLINICAL PROCEDURES USING THE FOLLOWING
23 CONSIDERATIONS:

24 (I) WHETHER THE PROCEDURE CONTAINS A HIGH RISK FOR
25 INFECTION CONTRACTION;

26 (II) WHETHER THE TYPE OR TYPES OF INFECTION PRESENT A
27 SERIOUS RISK TO THE PATIENT'S HEALTH OR LIFE; AND

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(III) ANY OTHER FACTORS DETERMINED BY THE ADVISORY COMMITTEE.

(d) IF THE ADVISORY COMMITTEE DETERMINES THAT IT IS UNABLE TO IDENTIFY AT LEAST TWO CLINICAL PROCEDURES FOR ADDITION TO THE DATA COLLECTED BY THE DEADLINE, THE COMMITTEE SHALL REPORT TO THE DEPARTMENT ITS REASONS FOR NOT IDENTIFYING AT LEAST TWO NEW CLINICAL PROCEDURES.

(6) THE ADVISORY COMMITTEE MAY RECOMMEND THAT HOSPITALS REPORT PROCESS MEASURES, IN ADDITION TO THOSE LISTED IN SUBSECTIONS (1) AND (5) OF THIS SECTION, TO ACCOMMODATE BEST PRACTICES FOR EFFECTIVE PREVENTION OF INFECTION.

25-3-603. Department reports. (1) ON OR BEFORE JULY 31, 2008, AND EACH JULY 31 THEREAFTER, THE DEPARTMENT SHALL SUBMIT TO THE HEALTH AND HUMAN SERVICES COMMITTEES OF THE HOUSE OF REPRESENTATIVES AND OF THE SENATE A REPORT SUMMARIZING THE RISK-ADJUSTED HOSPITAL DATA. THE DEPARTMENT SHALL POST THE REPORT ON ITS WEBSITE.

(2) THE DEPARTMENT SHALL ISSUE SEMI-ANNUAL INFORMATIONAL BULLETINS SUMMARIZING ALL OR PART OF THE INFORMATION SUBMITTED IN THE HOSPITAL REPORTS.

(3) (a) ALL DATA IN REPORTS ISSUED BY THE DEPARTMENT SHALL BE RISK-ADJUSTED CONSISTENT WITH THE STANDARDS OF THE NATIONAL HEALTHCARE SAFETY NETWORK.

(b) THE ANNUAL REPORT SHALL COMPARE THE RISK-ADJUSTED, HOSPITAL-ACQUIRED INFECTION RATES, COLLECTED UNDER SECTION 25-3-602, FOR EACH INDIVIDUAL HOSPITAL IN THE STATE. THE

1 DEPARTMENT, IN CONSULTATION WITH THE ADVISORY COMMITTEE, SHALL
2 MAKE THIS COMPARISON AS EASY TO COMPREHEND AS POSSIBLE. THE
3 REPORT SHALL INCLUDE AN EXECUTIVE SUMMARY, WRITTEN IN PLAIN
4 LANGUAGE, THAT INCLUDES, BUT IS NOT LIMITED TO, A DISCUSSION OF
5 FINDINGS, CONCLUSIONS, AND TRENDS CONCERNING THE OVERALL STATE
6 OF HOSPITAL-ACQUIRED INFECTIONS IN THE STATE, INCLUDING A
7 COMPARISON TO PRIOR YEARS WHEN AVAILABLE. THE REPORT MAY
8 INCLUDE POLICY RECOMMENDATIONS AS APPROPRIATE.

9 (c) THE DEPARTMENT SHALL PUBLICIZE THE REPORT AND ITS
10 AVAILABILITY AS WIDELY AS PRACTICAL TO INTERESTED PARTIES,
11 INCLUDING BUT NOT LIMITED TO HOSPITALS, PROVIDERS, MEDIA
12 ORGANIZATIONS, HEALTH INSURERS, HEALTH MAINTENANCE
13 ORGANIZATIONS, PURCHASERS OF HEALTH INSURANCE, ORGANIZED LABOR,
14 CONSUMER OR PATIENT ADVOCACY GROUPS, AND INDIVIDUAL CONSUMERS.
15 THE ANNUAL REPORT SHALL BE MADE AVAILABLE TO ANY PERSON UPON
16 REQUEST.

17 (d) A HOSPITAL REPORT OR DEPARTMENT DISCLOSURE MAY NOT
18 CONTAIN INFORMATION IDENTIFYING A PATIENT, EMPLOYEE, OR LICENSED
19 HEALTH CARE PROFESSIONAL IN CONNECTION WITH A SPECIFIC INFECTION
20 INCIDENT.

21 **25-3-604. Privacy.** COMPLIANCE WITH THIS PART 6 SHALL NOT
22 VIOLATE A PATIENT'S RIGHT TO CONFIDENTIALITY. A PATIENT'S SOCIAL
23 SECURITY NUMBER AND ANY OTHER INFORMATION THAT COULD BE USED
24 TO IDENTIFY A PATIENT SHALL NOT BE RELEASED, NOTWITHSTANDING ANY
25 OTHER PROVISION OF LAW.

26 **25-3-605. Confidentiality.** (1) EXCEPT AS PROVIDED BY
27 SUBSECTION (5) OF THIS SECTION, ALL INFORMATION AND MATERIALS

1 OBTAINED AND COMPILED BY THE DEPARTMENT UNDER THIS PART 6 OR
2 COMPILED BY A HOSPITAL UNDER THIS PART 6, INCLUDING ALL RELATED
3 INFORMATION AND MATERIALS, ARE CONFIDENTIAL; ARE NOT SUBJECT TO
4 DISCLOSURE, DISCOVERY, SUBPOENA, OR OTHER MEANS OF LEGAL
5 COMPULSION FOR RELEASE TO ANY PERSON, SUBJECT TO SUBSECTION (2)
6 OF THIS SECTION; AND MAY NOT BE ADMITTED AS EVIDENCE OR
7 OTHERWISE DISCLOSED IN A CIVIL, CRIMINAL, OR ADMINISTRATIVE
8 PROCEEDING.

9 (2) THE CONFIDENTIAL PROTECTIONS UNDER SUBSECTION (1) OF
10 THIS SECTION SHALL APPLY WITHOUT REGARD TO WHETHER THE
11 INFORMATION OR MATERIALS ARE OBTAINED FROM OR COMPILED BY A
12 HOSPITAL OR AN ENTITY THAT HAS OWNERSHIP OR MANAGEMENT
13 INTERESTS IN A HOSPITAL.

14 (3) THE TRANSFER OF INFORMATION OR MATERIALS UNDER THIS
15 PART 6 IS NOT A WAIVER OF A PRIVILEGE OR PROTECTION GRANTED UNDER
16 LAW.

17 (4) INFORMATION REPORTED BY A HOSPITAL UNDER THIS PART 6
18 AND ANALYSES, PLANS, RECORDS, AND REPORTS OBTAINED, PREPARED, OR
19 COMPILED BY A HOSPITAL UNDER THIS PART 6 AND ALL RELATED
20 INFORMATION AND MATERIALS ARE SUBJECT TO AN ABSOLUTE PRIVILEGE
21 AND SHALL NOT BE USED IN ANY FORM AGAINST THE HOSPITAL, ITS
22 AGENTS, EMPLOYEES, PARTNERS, ASSIGNEES, OR INDEPENDENT
23 CONTRACTORS IN ANY CIVIL, CRIMINAL, OR ADMINISTRATIVE PROCEEDING,
24 REGARDLESS OF THE MEANS BY WHICH A PERSON CAME INTO POSSESSION
25 OF THE INFORMATION, ANALYSIS, PLAN, RECORD, REPORT, OR RELATED
26 INFORMATION OR MATERIALS.

27 (5) THE PROVISIONS OF THIS SECTION REGARDING THE

1 CONFIDENTIALITY OF INFORMATION OR MATERIALS COMPILED OR
2 REPORTED BY A HOSPITAL IN COMPLIANCE WITH OR AS AUTHORIZED UNDER
3 THIS PART 6 SHALL NOT RESTRICT ACCESS, TO THE EXTENT AUTHORIZED BY
4 LAW, BY THE PATIENT OR THE PATIENTS' LEGALLY AUTHORIZED
5 REPRESENTATIVE TO RECORDS OF THE PATIENT'S MEDICAL DIAGNOSIS OR
6 TREATMENT OR TO OTHER PRIMARY HEALTH RECORDS.

7 **25-3-606. Penalties.** (1) A DETERMINATION THAT A HOSPITAL
8 HAS VIOLATED THE PROVISIONS OF THIS PART 6 MAY RESULT IN THE
9 FOLLOWING:

10 (a) TERMINATION OF LICENSURE OR OTHER SANCTIONS RELATED
11 TO LICENSURE UNDER PART 1 OF THIS ARTICLE; OR

12 (b) A CIVIL PENALTY OF UP TO ONE THOUSAND DOLLARS PER
13 VIOLATION FOR EACH DAY THE HOSPITAL IS IN VIOLATION OF THIS PART 6.

14 **25-3-607. Regulatory oversight.** THE DEPARTMENT SHALL BE
15 RESPONSIBLE FOR ENSURING COMPLIANCE WITH THIS PART 6 AS A
16 CONDITION OF LICENSURE UNDER PART 1 OF THIS ARTICLE AND SHALL
17 ENFORCE COMPLIANCE ACCORDING TO THE PROVISIONS IN PART 1 OF THIS
18 ARTICLE.

19 **SECTION 2.** 25-3-103 (1) (a), Colorado Revised Statutes, is
20 amended to read:

21 **25-3-103. License denial or revocation - provisional license.**

22 (1) (a) Application for a new or renewal license under this part 1 may be
23 denied to an applicant not meeting the requirements of this part 1 OR PART
24 6 OF THIS ARTICLE and the rules of the department of public health and
25 environment. A license may be revoked for like reasons. The department
26 of public health and environment may, upon such denial or revocation,
27 grant a provisional license, valid for ninety days, upon payment of a fee

1 of one hundred fifty dollars, to allow such applicant to comply with the
2 requirements for a regular license. A second provisional license may be
3 issued, for a like term and fee, if necessary in the opinion of the
4 department of public health and environment, to effect compliance. No
5 further provisional licenses may be issued for the then current year after
6 the second issuance.

7 **SECTION 3. Safety clause.** The general assembly hereby finds,
8 determines, and declares that this act is necessary for the immediate
9 preservation of the public peace, health, and safety.


 Colorado *Legislative Council Staff*
STATE
FISCAL IMPACT

Drafting Number: LLS 06-0128
Prime Sponsor(s): Rep. McCluskey
 Sen. Keller

Date: December 7, 2005
Bill Status: Health Care Task Force
Fiscal Analyst: Amy Larsen (303-866-3488)

TITLE: CONCERNING PUBLIC REPORTING OF HOSPITAL-ACQUIRED INFECTIONS.

Fiscal Impact Summary	FY 2006/2007	FY 2007/2008
State Revenues		
General Fund		
State Expenditures		
General Fund	\$52,626	\$76,166
FTE Position Change	0.6 FTE	1.0 FTE
Effective Date: Upon signature of the Governor.		
Appropriation Summary for FY 2006/2007:		
Department of Public Health and Environment: \$52,626 GF and 0.6 FTE		
Local Government Impact: None.		

Summary of Legislation

This Health Care Task Force bill includes the following provisions concerning public reporting of hospital-acquired infections:

- requires hospitals to collect data on hospital-acquired infections and regularly report such data to the National Healthcare Safety Network beginning September 30, 2007;
- requires the Department of Public Health and Environment to submit an annual report summarizing and analyzing the data from the hospitals to the Health and Human Services Committees of the General Assembly beginning in 2008;
- requires the department to make annual and semi-annual reports available to the public;
- creates an advisory committee of health care professionals to assist the department in the development of all aspects of the information to be collected; and
- establishes civil penalties for failure to comply with the data collection and reporting requirements.

State Revenues

Civil penalties of up to \$1,000 may be imposed for each day a hospital is in violation of the specifications outlined in the bill. At this time, the fiscal note assumes that no penalties will be assessed and collected until FY 2008-09. Since hospitals are not required to start reporting data until September 2007, it would be some time after that date before the department could assess compliance, complete the penalty process, and collect the fine. Revenue from civil penalties not otherwise appropriated in the bill are credited to the General Fund. The fiscal note assumes less than \$5,000 per year in civil penalty revenue starting in FY 2008-09.

State Expenditures

This bill will increase expenditures of the Department of Public Health and Environment by an estimated \$52,626 General Fund and 0.6 FTE in FY 2006-07 as shown in Table I.

Table I.		
Estimated Expenditures for the Department of Public Health and Environment		
	FY 2006/07	FY 2007/08
Personal Services & Operating Expenses	\$49,894	\$73,434
FTE	0.6	1.0
Advisory Committee Reimbursement	\$2,732	\$2,732
Total Expenses	\$52,626	\$76,166

The fiscal note assumes the following:

Personal Services/Operating Expenses — costs are identified at \$49,894 in FY 2006-07 and \$73,434 in FY 2007-08. The department will require 0.6 FTE in FY 2006-07 and 1.0 FTE in subsequent fiscal years based on the following state classifications and duties:

0.4 FTE, Health Professional IV will be required to provide direction for the reporting process; provide technical assistance and follow-up on incomplete or missing reports on an ongoing basis to the 223 hospitals, ambulatory surgical centers and dialysis treatment clinics required to report infection rates; review data, conduct analyses and prepare reports; and conduct research for the advisory committee. The workload increases the second year to 0.6 FTE due to the effective date of the bill and reporting requirements.

0.1 FTE, General Professional IV will be required as a health educator to assist in writing the reports; publicize and distribute the reports; answer questions and provide information to the public; and organize and support the advisory committee meetings. The workload increases the second year to 0.3 FTE due to the effective date of the bill and reporting requirements.

0.1 FTE management level, will be required for oversight of the program.

Advisory Committee Reimbursement — costs are identified at \$2,732 in FY 2006-07 and FY 2007-08. Although the advisory committee members are required to serve without compensation, the fiscal note assumes reimbursement costs for actual and necessary expenses to attend meetings. The 11-member advisory committee is anticipated to meet 4 times in each of the first two years and twice annually thereafter. Reimbursement of such expenses is customary with other statutory boards and committees within the department.

Other State Impact

Department of Health Care Policy and Financing - Estimated Medicaid Savings. Evidence shows that mandatory reporting of hospital-acquired infections reduces the number of infections due to increased awareness of the issue. Thus, the state can expect Medicaid expenditures attributed to hospital-acquired infections to decrease as a result of this bill. The department performed an analysis of claims paid for certain diagnosis codes both with and without infections and identified a maximum potential savings of \$826,316 from FY 2004-05 data. The same analysis was performed on data from FY 2003-04 which identified approximately \$3 million potential savings. The \$2.2 million difference between the two estimates is due primarily to neonate cases with hospital-acquired infections in FY 2003-04.

Savings of \$0.8 to \$3 million per year are estimated as a result of this bill. However, since current hospital rates are based on prior year claims, this savings is not expected to be realized until at least a year after the bill has been fully implement or FY 2008-09. Detailed information on the potential Medicaid savings is available in the Legislative Council Fiscal Note Section.

State Appropriations

The Department of Public Health and Environment requires an appropriation of \$52,626 General Fund and 0.6 FTE for FY 2006-07.

Departments Contacted

Public Health and Environment Health Care Policy and Financing Law

Second Regular Session
Sixty-fifth General Assembly
STATE OF COLORADO

Bill B

DRAFT

LLS NO. 06-0219.01 Michele Hanigsberg

SENATE BILL

SENATE SPONSORSHIP

Tochtrop, Gordon, Keller, and Mitchell

HOUSE SPONSORSHIP

Todd, Butcher, and McCluskey

Senate Committees

House Committees

A BILL FOR AN ACT

101 CONCERNING THE PROVISION OF HEALTH CARE SERVICES THROUGH
102 THE USE OF TELEMEDICINE UNDER THE COLORADO MEDICAL
103 ASSISTANCE PROGRAM.

Bill Summary

(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments that may be subsequently adopted.)

Health Care Task Force. Requires the department of health care policy and financing to seek the necessary federal authorization for the reimbursement and provision of home health care services by certified home health agencies through the use of telemedicine. Specifies that the provision of home health care services through the use of telemedicine shall not be limited to the statewide managed care system.

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.
Capital letters indicate new material to be added to existing statute.
Dashes through the words indicate deletions from existing statute.

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

2 **SECTION 1.** Part 4 of article 4 of title 26, Colorado Revised
3 Statutes, is amended BY THE ADDITION OF A NEW SECTION to
4 read:

5 **26-4-421.5. Telemedicine - home health care - federal**
6 **authorization.** (1) FOR PURPOSES OF THIS SECTION, "TELEMEDICINE"
7 SHALL HAVE THE SAME MEANING AS SET FORTH IN SECTION 12-36-106 (1)
8 (g), C.R.S.

9 (2) THE STATE DEPARTMENT SHALL SEEK THE NECESSARY FEDERAL
10 AUTHORIZATION FOR THE REIMBURSEMENT AND PROVISION OF HOME
11 HEALTH CARE SERVICES, INCLUDING, BUT NOT LIMITED TO, MEDICAL
12 EQUIPMENT, DEVICES, AND SOFTWARE NECESSARY FOR THE PROVISION OF
13 SUCH SERVICES, BY CERTIFIED HOME HEALTH AGENCIES THROUGH THE USE
14 OF TELEMEDICINE. THE PROVISION OF HOME HEALTH CARE SERVICES
15 THROUGH THE USE OF TELEMEDICINE SHALL NOT BE LIMITED TO THE
16 STATEWIDE MANAGED CARE SYSTEM CREATED IN SUBPART 2 OF PART 1 OF
17 THIS ARTICLE.

18 **SECTION 2. Effective date.** This act shall take effect at 12:01
19 a.m. on the day following the expiration of the ninety-day period after
20 final adjournment of the general assembly that is allowed for submitting
21 a referendum petition pursuant to article V, section 1 (3) of the state
22 constitution (August 9, 2006, if adjournment sine die is on May 10,
23 2006); except that, if a referendum petition is filed against this act or an
24 item, section, or part of this act within such period, then the act, item,
25 section, or part, if approved by the people, shall take effect on the date of

1 the official declaration of the vote thereon by proclamation of the
2 governor.

DRAFT

Bill B

Colorado Legislative Council Staff
NO FISCAL IMPACT

Drafting Number: LLS 06-0219

Date: December 12, 2005

Prime Sponsor(s): Sen. Tochtrop
Rep. Todd

Bill Status: Health Care Task Force

Fiscal Analyst: Janis Baron (303-866-3523)

TITLE: CONCERNING THE PROVISION OF HEALTH CARE SERVICES THROUGH THE USE OF TELEMEDICINE UNDER THE COLORADO MEDICAL ASSISTANCE PROGRAM.

Summary of Assessment

This interim committee bill, recommended by the Health Care Task Force, **requires** the Department of Health Care Policy and Financing to seek the necessary federal authorization for the reimbursement and provision of home health care services by certified home health agencies through the use of telemedicine. The bill **does not require** the department to implement the provision of home health care services through telemedicine; statutory authorization would be required to do so. The bill is effective 90 days following final adjournment of the General Assembly (August 9, 2006, if adjournment sine die is on May 10, 2006).

In its current form, the bill is assessed at having no fiscal impact. The department can submit a State Plan amendment to the federal Centers for Medicare and Medicaid Services to seek authorization for the reimbursement and provision of home health care services through the use of telemedicine without the need for additional resources. Should there be a requirement that the department provide home health care services through telemedicine, the total cost is estimated at \$866,910 in year one and \$101,652 in year two.

Departments Contacted

Health Care Policy and Financing

Second Regular Session
Sixty-fifth General Assembly
STATE OF COLORADO

Bill C

DRAFT

LLS NO. 06-0218.01 Michele Hanigsberg

SENATE BILL

SENATE SPONSORSHIP

Mitchell, Gordon, Keller, and Tochtrop

HOUSE SPONSORSHIP

Butcher, Frangas, McCluskey, and Todd

Senate Committees

House Committees

A BILL FOR AN ACT

101 **CONCERNING A REPORT BY THE DEPARTMENT OF CORRECTIONS**
102 **REGARDING THE PROVISION OF MEDICAL SERVICES TO STATE**
103 **INMATES THROUGH THE USE OF TELEMEDICINE.**

Bill Summary

(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments that may be subsequently adopted.)

Health Care Task Force. Requires the department of corrections to study and report on the state's options for providing medical services to state inmates in correctional facilities through the use of telemedicine. Requires the report to be presented to the health and human services committees of the house of representatives and the senate on or before February 1, 2007. Specifies, at a minimum, what the report shall include.

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.
Capital letters indicate new material to be added to existing statute.
Dashes through the words indicate deletions from existing statute.

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

2 **SECTION 1.** Part 1 of article 1 of title 17, Colorado Revised
3 Statutes, is amended BY THE ADDITION OF A NEW SECTION to
4 read:

5 **17-1-113.3. Telemedicine - study - report - repeal.** (1) FOR
6 PURPOSES OF THIS SECTION, "TELEMEDICINE" SHALL HAVE THE SAME
7 MEANING AS SET FORTH IN SECTION 12-36-106 (1) (g), C.R.S.

8 (2) THE DEPARTMENT SHALL STUDY THE STATE'S OPTIONS FOR
9 PROVIDING MEDICAL SERVICES TO STATE INMATES IN CORRECTIONAL
10 FACILITIES THROUGH THE USE OF TELEMEDICINE. ON OR BEFORE
11 FEBRUARY 1, 2007, THE DEPARTMENT SHALL REPORT TO THE HEALTH AND
12 HUMAN SERVICES COMMITTEES OF THE HOUSE OF REPRESENTATIVES AND
13 THE SENATE REGARDING THE STATE'S OPTIONS FOR PROVIDING MEDICAL
14 SERVICES TO STATE INMATES IN CORRECTIONAL FACILITIES THROUGH THE
15 USE OF TELEMEDICINE. THE REPORT SHALL ADDRESS, AT A MINIMUM:

16 (a) THE TECHNOLOGY AVAILABLE TO THE DEPARTMENT FOR THE
17 PROVISION OF MEDICAL SERVICES TO STATE INMATES THROUGH THE USE
18 OF TELEMEDICINE;

19 (b) THE TECHNOLOGICAL AND TRAINING NEEDS OF THE
20 DEPARTMENT IN ORDER TO PROVIDE MEDICAL SERVICES TO STATE INMATES
21 THROUGH THE USE OF TELEMEDICINE AND THE ESTIMATED COST OF
22 MEETING THOSE NEEDS;

23 (c) THE ESTIMATED COST SAVINGS ASSOCIATED WITH PROVIDING
24 MEDICAL SERVICES TO STATE INMATES THROUGH THE USE OF
25 TELEMEDICINE. THE DEPARTMENT SHALL CONSIDER OTHER STATES'
26 EXPERIENCES WHEN CALCULATING THE COST SAVINGS ASSOCIATED WITH

1 TELEMEDICINE.

2 (d) THE ESTIMATED IMPACT ON LOCAL ECONOMIES IF THE
3 DEPARTMENT IMPLEMENTS THE USE OF TELEMEDICINE TO PROVIDE
4 MEDICAL SERVICES TO STATE INMATES.

5 (e) THIS SECTION IS REPEALED, EFFECTIVE JULY 1, 2007.

6 **SECTION 2. Effective date.** This act shall take effect at 12:01
7 a.m. on the day following the expiration of the ninety-day period after
8 final adjournment of the general assembly that is allowed for submitting
9 a referendum petition pursuant to article V, section 1 (3) of the state
10 constitution (August 9, 2006, if adjournment sine die is on May 10,
11 2006); except that, if a referendum petition is filed against this act or an
12 item, section, or part of this act within such period, then the act, item,
13 section, or part, if approved by the people, shall take effect on the date of
14 the official declaration of the vote thereon by proclamation of the
15 governor.


Colorado Legislative Council Staff
STATE
FISCAL IMPACT

Drafting Number: LLS 06-0218
Prime Sponsor(s): Sen. Mitchell
 Rep. Butcher

Date: December 7, 2005
Bill Status: Health Care Task Force
Fiscal Analyst: Janis Baron (303-866-3523)

TITLE: CONCERNING A REPORT BY THE DEPARTMENT OF CORRECTIONS REGARDING THE PROVISION OF MEDICAL SERVICES TO STATE INMATES THROUGH THE USE OF TELEMEDICINE.

Fiscal Impact Summary	FY 2006/2007	FY 2007/2008
State Revenues		
State Expenditures		
General Fund	\$50,000	
FTE Position Change	0.0 FTE	0.0 FTE
Effective Date: 90 days following final adjournment of the General Assembly — August 9, 2006, if adjournment sine die is May 10, 2006		
Appropriation Summary for FY 2006/2007:		
Department of Corrections	\$50,000	GF
Local Government Impact: None		

Summary of Legislation

This interim committee bill, recommended by the Health Care Task Force, requires the Department of Corrections to study the state's options for providing medical services to state inmates in correctional facilities through the use of telemedicine. On or before February 1, 2007, the department is required to report its findings to the Health and Human Services Committees of the General Assembly. The bill specifies what the report is required to address.

State Expenditures

The bill is assessed at having a fiscal impact of \$50,000 General Fund in FY 2006-07 only. Presently, the Department of Corrections does not have the expertise to fully evaluate the use of telemedicine to provide medical services to state inmates as mandated in the bill. The department will require contractual services from a medical consulting firm to perform the following tasks:

Bill C

- inventory/evaluate current technology and determine the technological and training needs of the department to provide medical services through telemedicine;
- inventory current medical equipment and determine additional equipment needs;
- determine staffing requirements;
- identify universities and large medical and/or medical research facilities that would work with the department to incorporate telemedicine into its medical services;
- identify those correctional facilities where telemedicine could be used effectively;
- identify training needs and utilization procedures;
- estimate cost savings associated with providing medical services through telemedicine;
- estimate the impact on local economies should the department use telemedicine to provide medical services; and
- prepare the required report.

State Appropriations

For FY 2006-07, the Department of Corrections will require an appropriation of \$50,000 General Fund.

Departments Contacted

Corrections