

25-37-101. Health care contracts - required provisions - definitions.

(1) Effective January 1, 2008, a person or entity that contracts with a health care provider shall comply with this article and shall include the provisions required by this article in the contract. A contract in existence prior to January 1, 2008, that is renewed or renews by its terms shall comply with this article no later than December 31, 2008.

(2) As used in this article, unless the context otherwise requires:

(a) "Category of coverage" means one of the following types of coverage offered by a person or entity:

(I) Health maintenance organization plans;

(II) Any other commercial plan or contract that is not a health maintenance organization plan;

(III) Medicare;

(IV) Medicaid; or

(V) Workers' compensation.

(b) "Edit" means a practice or procedure pursuant to which one or more adjustments are made regarding procedure codes, including the American medical association's current procedural terminology code, also known as a "CPT code", and the centers for medicare and medicaid services health care common procedure coding system, also known as "HCPCS", that results in:

(I) Payment for some, but not all, of the codes;

(II) Payment for a different code;

(III) A reduced payment as a result of services provided to a patient that are claimed under more than one code on the same service date;

(IV) A reduced payment related to a modifier used with a procedure code; or

(V) A reduced payment based on multiple units of the same code billed for a single date of service.

(c) "Health care contract" or "contract" means a contract entered into or renewed between a person or entity and a health care provider for the delivery of health care services to others.

(d) "Health care provider" means a person licensed or certified in this state to practice medicine, pharmacy, chiropractic, nursing, physical therapy, podiatry, dentistry, optometry, occupational therapy, or other healing arts. "Health care provider" also means an ambulatory surgical center, a licensed pharmacy or provider of pharmacy services, and a professional corporation or other corporate entity consisting of licensed health care providers as permitted by the laws of this state.

(e) (I) "Material change" means a change to a contract that decreases the health care provider's payment or compensation, changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expense, replaces the maximum allowable cost list used with a new and different maximum allowable cost list by a person or entity for reimbursement of generic prescription drug claims, or adds a new category of coverage. A material change does not include:

(A) A decrease in payment or compensation resulting solely from a change in a published fee schedule upon

EXHIBIT A

which the payment or compensation is based and the date of applicability is clearly identified in the contract;

(B) A decrease in payment or compensation resulting from a change in the fee schedule specified in a contract for pharmacy services such as a change in a fee schedule based on average wholesale price or maximum allowable cost;

(C) A decrease in payment or compensation that was anticipated under the terms of the contract, if the amount and date of applicability of the decrease is clearly identified in the contract;

(D) An administrative change that may significantly increase the provider's administrative expense, the specific applicability of which is clearly identified in the contract;

(E) Changes to an existing prior authorization, precertification, notification, or referral program that do not substantially increase the provider's administrative expense; or

(F) Changes to an edit program or to specific edits; however, the health care provider shall be provided notice of the changes pursuant to subparagraph (II) of this paragraph (e), and the notice shall include information sufficient for the health care provider to determine the effect of the change.

(II) If a change to the contract is administrative only and is not a material change, the change shall be effective upon at least fifteen days' notice to the health care provider. All other notices shall be provided pursuant to the contract.

(f) "Person or entity" means a person or entity that has a primary business purpose of contracting with health care providers for the delivery of health care services.

(3) (a) Each contract shall have provided with it a summary disclosure form disclosing, in plain language, the following:

(I) The terms governing compensation and payment;

(II) Any category of coverage for which the health care provider is to provide service;

(III) The duration of the contract and how the contract may be terminated;

(IV) The identity of the person or entity responsible for the processing of the health care provider's claims for compensation or payment;

(V) Any internal mechanism required by the person or entity to resolve disputes that arise under the terms or conditions of the contract; and

(VI) The subject and order of addenda, if any, to the contract.

(b) The summary disclosure form required by paragraph (a) of this subsection (3) shall be for informational purposes only and shall not be a term or condition of the contract; however, such disclosure shall reasonably summarize the applicable contract provisions.

(c) If the contract provides for termination for cause by either party, the contract shall state the reasons that may be used for termination for cause, which terms shall not be unreasonable, and the contract shall state the time by which notice of termination for cause shall be provided and to whom the notice shall be given.

(d) The person or entity shall identify any utilization review or management, quality improvement, or similar program the person or entity uses to review, monitor, evaluate, or assess the services provided pursuant to a contract. The policies, procedures, or guidelines of such program applicable to a provider shall be disclosed upon request of the health care provider within fourteen days after the date of the request.

EXHIBIT A

(4) (a) The disclosure of payment and compensation terms pursuant to subsection (3) of this section shall include information sufficient for the health care provider to determine the compensation or payment for the health care services and shall include the following:

(I) The manner of payment, such as fee-for-service, capitation, or risk sharing;

(II) (A) The methodology used to calculate any fee schedule, such as relative value unit system and conversion factor, percentage of medicare payment system, or percentage of billed charges. As applicable, the methodology disclosure shall include the name of any relative value system; its version, edition, or publication date; any applicable conversion or geographic factor; and any date by which compensation or fee schedules may be changed by such methodology if allowed for in the contract.

(B) The fee schedule for codes reasonably expected to be billed by the health care provider for services provided pursuant to the contract, and, upon request, the fee schedule for other codes used by or which may be used by the health care provider. Such fee schedule shall include, as may be applicable, service or procedure codes such as current procedural terminology (CPT) codes or health care common procedure coding system codes and the associated payment or compensation for each service code.

(C) The fee schedule required in sub-subparagraph (B) of this subparagraph (II) may be provided electronically.

(D) A fee schedule for the codes described by sub-subparagraph (B) of this subparagraph (II) shall be provided when a material change related to payment or compensation occurs. Additionally, a health care provider may request that a written fee schedule be provided up to twice per year, and the person or entity must provide such fee schedule promptly.

(III) The person or entity shall state the effect of edits, if any, on payment or compensation. A person or entity may satisfy this requirement by providing a clearly understandable, readily available mechanism, such as through a web site, that allows a health care provider to determine the effect of edits on payment or compensation before service is provided or a claim is submitted.

(b) Notwithstanding any provision of this subsection (4) to the contrary, disclosure of a fee schedule or the methodology used to calculate a fee schedule is not required:

(I) From a person or entity if the fee schedule is for a plan for dental services, its providers include licensed dentists, the fee schedule is based upon fees filed with the person or entity by dental providers, and the fee schedule is revised from time to time based upon such filings. Specific numerical parameters are not required to be disclosed.

(II) If the fee schedule is for pharmacy services or drugs such as a fee schedule based on use of national drug codes.

(5) Upon completion of processing of a claim, the person or entity shall provide information to the health care provider stating how the claim was adjudicated and the responsibility for any outstanding balance of any party other than the person or entity.

(6) When a proposed contract is presented by a person or entity for consideration by a health care provider, the person or entity shall provide in writing or make reasonably available the information required in subsection (4) of this section. If the information is not disclosed in writing, it shall be disclosed in a manner that allows the health care provider to timely evaluate the payment or compensation for services under the proposed contract. The disclosure obligations in this article shall not prevent a person or entity from requiring a reasonable confidentiality agreement regarding the terms of a proposed contract.

(7) (a) A material change to a contract shall occur only if the person or entity provides in writing to the health care provider the proposed change and gives ninety days' notice before the effective date of the

EXHIBIT A

change. The writing shall be conspicuously entitled "notice of material change to contract".

(b) If the health care provider objects in writing to the material change within fifteen days and there is no resolution of the objection, either party may terminate the contract upon written notice of termination provided to the other party not later than sixty days before the effective date of the material change.

(c) If the health care provider does not object to the material change pursuant to paragraph (b) of this subsection (7), the change shall be effective as specified in the notice of material change to the contract.

(d) If a material change is the addition of a new category of coverage and the health care provider objects, the addition shall not be effective as to the health care provider, and the objection shall not be a basis upon which the person or entity may terminate the contract.

(8) Notwithstanding subsection (6) of this section, a contract may be modified by operation of law as required by any applicable state or federal law or regulation, and the person or entity may disclose this change by any reasonable means.

(9) Nothing in this article shall be construed to require the renegotiation of a contract in existence before the applicable compliance date in this article, and any disclosure required by this article for such contracts may be by notice to the health care provider.

(10) A person or entity shall not assign, allow access to, sell, rent, or give the person's or entity's rights to the health care provider's services pursuant to the person's or entity's contract unless he or she complies with paragraph (a), (b), or (c) of this subsection (10) and also complies with paragraphs (d) and (e) of this subsection (10) as follows:

(a) The third party accessing the health care provider's services under the contract is an employer or other entity providing coverage for health care services to its employees or members and such employer or entity has, with the person or entity contracting with the health care provider, a contract for the administration or processing of claims for payment or service provided pursuant to the contract with the health care provider;

(b) The third party accessing the health care provider's services under the contract is an affiliate of, subsidiary of, or is under common ownership or control with the person or entity; or, is providing or receiving administrative services from the person or entity or an affiliate of, or subsidiary of, or is under common ownership or control with the person or entity;

(c) The health care contract specifically provides that it applies to network rental arrangements and states that it is for the purpose of assigning, allowing access to, selling, renting, or giving the person's or entity's rights to the health care provider's services;

(d) The individuals receiving services under the health care provider's contract are provided with appropriate identification stating where claims should be sent and where inquiries should be directed; and

(e) The third party accessing the health care provider's services through the health care provider's contract is obligated to comply with all applicable terms and conditions of the contract; except that a self-funded plan receiving administrative services from the person or entity or its affiliates shall be solely responsible for payment to the provider.

(11) Except as permitted by this article, a person or entity shall not require, as a condition of contracting, that a health care provider waive or forego any right or benefit to which the health care provider may be entitled under state or federal law or regulation that provides legal protections to a person solely based on the person's status as a health care provider providing services in this state.

(12) Upon sixty days' notice, a health care provider may decline to provide service pursuant to a contract to new patients covered by the person or entity. The notice shall state the reason or reasons for this action. For the purposes of this subsection (12), "new patients" means those patients who have not received services

EXHIBIT A

- from the health care provider in the immediately preceding three years. A patient shall not become a "new patient" solely by changing coverage from one person or entity to another person or entity.
- (13) A term for compensation or payment shall not survive the termination of a contract, except for a continuation of coverage required by law or with the agreement of the health care provider.
- (14) A contract shall not preclude its use or disclosure to a third party for the purpose of enforcing the provisions of this article or enforcing other state or federal law. The third party shall be bound by the confidentiality requirements set forth in the contract or otherwise.
- (15) In addition to the provisions of paragraph (e) of subsection (2) of this section, a contract with a duration of less than two years shall provide to each party a right to terminate the contract without cause, which termination shall occur with at least ninety days' written notice. For contracts with a duration of two or more years, termination without cause may be as specified in the contract.
- (16) This article shall not apply to:
- (a) An exclusive contract with a single medical group in a specific geographic area to provide or arrange for health care services; however, this article shall apply to contracts for health care services between the medical group and other medical groups;
 - (b) A contract or agreement for the employment of a health care provider or a contract or agreement between health care providers;
 - (c) A contract or arrangement entered into by a hospital or health care facility that is licensed or certified pursuant to section [25-3-101](#);
 - (d) A contract between a health care provider and the state or federal government or their agencies for health care services provided through a program for workers' compensation, medicaid, medicare, the children's basic health plan provided for in article [8](#) of title [25.5](#), C.R.S., or the Colorado indigent care program created in part 1 of article [3](#) of title [25.5](#), C.R.S.;
 - (e) Contracts for pharmacy benefit management, such as with a pharmacy benefit management firm as defined in section [10-16-102](#), C.R.S.; except that this exclusion shall not apply to a contract for health care services between a person or entity and a pharmacy, a pharmacist, or a professional corporation or corporate entity consisting of pharmacies or pharmacists as permitted by the laws of this state; or
 - (f) A contract or arrangement entered into by a hospital or health care facility that is licensed or certified pursuant to section [25-3-101](#), or any outpatient service provider that has entered into a joint venture with the hospital or is owned by the hospital or health care facility.
- (17) A contract between a pharmacist or a pharmacy and a pharmacy benefit manager, such as a pharmacy benefit management firm as defined in section [10-16-102](#), C.R.S., shall be terminated if the federal drug enforcement agency or other federal law enforcement agency ceases the operations of the pharmacist or pharmacy due to alleged or actual criminal activity.
- (18) Notwithstanding the applicable compliance date requirement in subsection (1) of this section, a domestic nonprofit health plan shall comply with this article within twelve months after the applicable compliance date.
- (19) A contract subject to this article may include an agreement for binding arbitration.
- (20) (a) With respect to the enforcement of this article, including arbitration, there shall be available:
- (I) Private rights of action at law and in equity;

EXHIBIT A

(II) Equitable relief, including injunctive relief;

(III) Reasonable attorney fees when the health care provider is the prevailing party in an action to enforce this article, except to the extent that the violation of this article consisted of a mere failure to make payment pursuant to a contract;

(IV) The option to introduce as persuasive authority prior arbitration awards regarding a violation of this article.

(b) Arbitration awards related to the enforcement of this article may be disclosed to those who have a bona fide interest in the arbitration.

(21) No provision of this article shall be used to justify any act or omission by a health care provider that is prohibited by any applicable professional code of ethics or state or federal law prohibiting discrimination against any person.

Source: L. 2007: Entire article added, p. 296, § 1, effective August 3.

Editor's note: This section was contained in a 2007 act that was passed without a safety clause. For further explanation concerning the effective date, see page vii of this volume.