CHAPTER 196

HEALTH CARE POLICY AND FINANCING

SENATE BILL 95-078

BY SENATOR Rizzuto;
also REPRESENTATIVES Anderson, Chlouber, and Entz.

AN ACT

CONCERNING REVISIONS TO STATUTES GOVERNING SERVICES ADMINISTERED BY THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING, AND MAKING AN APPROPRIATION IN CONNECTION THEREWITH.

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

SECTION 1. 24-4-105 (14) (a) (I) and (14) (b), Colorado Revised Statutes, 1988 Repl. Vol., as amended, are amended to read:

24-4-105. Hearings and determinations. (14) (a) For the purpose of a decision by an agency which conducts a hearing or an initial decision by an administrative law judge or a hearing officer, the record shall include: All pleadings, applications, evidence, exhibits, and other papers presented or considered, matters officially noticed, rulings upon exceptions, any findings of fact and conclusions of law proposed by any party, and any written brief filed. The agency, administrative law judge, or hearing officer may permit oral argument. No ex parte material or representation of any kind offered without notice shall be received or considered by the agency, the administrative law judge, or by the hearing officer. The agency, an administrative law judge, or hearing officer, with the consent of all parties, may eliminate or summarize any part of the record where this may be done without affecting the decision. In any case in which the agency has conducted the hearing, the agency shall prepare, file, and serve upon each party its decision. In any case in which an administrative law judge or a hearing officer has conducted the hearing, the administrative law judge or the hearing officer shall prepare and file an initial decision which the agency shall serve upon each party, except where all parties with the consent of the agency have expressly waived their right to have an initial decision rendered by such administrative law judge or hearing officer. Each decision and initial decision shall include a statement of findings and conclusions upon all the material issues of fact, law, or discretion presented by the record and the appropriate

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

order, sanction, relief, or denial thereof. An appeal to the agency shall be made as follows:

(I) With regard to initial decisions regarding agency action by THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING, the state department of human services, or county department of social services, OR ANY CONTRACTOR ACTING FOR ANY SUCH DEPARTMENT, under section 26-1-106 (1) (a) OR 25.5-1-107 (1) (a), C.R.S., by filing exceptions within fifteen days after service of the initial decision upon the parties, unless extended by THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING, OR the state department OF HUMAN SERVICES, AS APPLICABLE, or unless a review has been initiated in accordance with this subparagraph (I) upon motion of the ~~state~~ APPLICABLE department within fifteen days after service of the initial decision. In the event a party fails to file an exception within fifteen days, the ~~state~~ APPLICABLE department may allow, upon a showing of good cause by the party, for an extension of up to an additional fifteen days to reconsider the final agency action.

(b) (I) IN THE ABSENCE OF AN EXCEPTION FILED PURSUANT TO SUBPARAGRAPH (I) OF PARAGRAPH (a) OF THIS SUBSECTION (14), THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING SHALL REVIEW THE INITIAL DECISION REGARDING AGENCY ACTION BY SUCH DEPARTMENT IN ACCORDANCE WITH A PROCEDURE ADOPTED BY THE MEDICAL SERVICES BOARD PURSUANT TO SECTION 25.5-1-107 (1), C.R.S.

(II) In the absence of an ~~appeal~~ EXCEPTION FILED pursuant to subparagraph (I) of paragraph (a) of this subsection (14), the executive director of the state department of human services shall review the initial decision REGARDING AGENCY ACTION BY SUCH DEPARTMENT in accordance with a procedure adopted by the state board OF HUMAN SERVICES pursuant to section 26-1-106 (1), C.R.S.

(III) In the absence of an ~~appeal~~ EXCEPTION FILED pursuant to subparagraph (II) of paragraph (a) of this subsection (14), the initial decision of any other agency shall become the decision of the agency, and, in such case, the evidence taken by the administrative law judge or the hearing officer need not be transcribed.

SECTION 2. 25.5-1-103, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

25.5-1-103. Definitions. As used in this title, unless the context otherwise requires:

(2.5) "STATE BOARD" OR "BOARD" MEANS THE MEDICAL SERVICES BOARD CREATED PURSUANT TO SECTION 25.5-1-301.

SECTION 3. 25.5-1-107 (1) (a) and (2), Colorado Revised Statutes, 1989 Repl. Vol., as amended, are amended to read:

25.5-1-107. Final agency action - administrative law judge - authority of executive director - direction to seek waiver of single state agency requirement. (1) (a) The executive director may appoint one or more persons to serve as administrative law judges for the state department pursuant to section 24-4-105, C.R.S., and pursuant to part 10 of article 30 of title 24, C.R.S., subject to

appropriations made to the department of administration. Except as provided in subsection (2) of this section, hearings conducted by the administrative law judge shall be considered initial decisions of the state department ~~which~~ AND shall be reviewed by the executive director or a designee of ~~such~~ THE executive director. ~~pursuant to section 24-4-105, C.R.S. Review by the executive director shall constitute final agency action.~~ IN THE EVENT EXCEPTIONS TO THE INITIAL DECISION ARE FILED PURSUANT TO SECTION 24-4-105 (14) (a) (I), C.R.S., SUCH REVIEW SHALL BE IN ACCORDANCE WITH SECTION 24-4-105 (15), C.R.S. IN THE ABSENCE OF ANY EXCEPTION FILED PURSUANT TO SECTION 24-4-105 (14) (a) (I), C.R.S., THE EXECUTIVE DIRECTOR SHALL REVIEW THE INITIAL DECISION IN ACCORDANCE WITH A PROCEDURE ADOPTED BY THE STATE BOARD. SUCH PROCEDURE SHALL BE CONSISTENT WITH FEDERAL MANDATES CONCERNING THE SINGLE STATE AGENCY REQUIREMENT. REVIEW BY THE EXECUTIVE DIRECTOR IN ACCORDANCE WITH SECTION 24-4-105 (15), C.R.S., OR THE PROCEDURE ADOPTED BY THE STATE BOARD PURSUANT TO THIS SECTION SHALL CONSTITUTE FINAL AGENCY ACTION. The administrative law judge may conduct hearings on appeals from decisions of county departments of social services brought by recipients of and applicants for public assistance and welfare ~~which~~ THAT are required by law in order for the state to qualify for federal funds, and the administrative law judge may conduct other hearings for the state department. Notice of any such hearing shall be served at least ten days prior to such hearing.

(2) Hearings initiated by a licensed or certified provider ~~or vendor~~ of services shall be conducted by an administrative law judge for the state department and shall be considered final agency action and subject to judicial review in accordance with the provisions of section 24-4-106, C.R.S., FOR ANY PARTY, INCLUDING THE STATE DEPARTMENT, WHICH SHALL BE CONSIDERED A PERSON FOR SUCH PURPOSES.

SECTION 4. 26-2-122.3 (1) (b), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended, and the said 26-2-122.3 (1) is further amended BY THE ADDITION OF A NEW PARAGRAPH, to read:

26-2-122.3. Adult foster care and home care allowance as services under certain public assistance programs - administered by department of health care policy and financing. (1) (b) In addition to the amount of assistance available pursuant to paragraph (a) of this subsection (1), the medical services board in the department of health care policy and financing, with the consent of the general assembly and subject to available funds, may provide a home care allowance for persons eligible to receive old age pension, aid to the needy disabled, or aid to the blind. For the purposes of this paragraph (b), "home care allowance" is a program that provides payments, subject to available appropriations, to functionally impaired persons who are, or who would be but for their income, eligible to receive old age pension pursuant to section 26-2-114, aid to the needy disabled pursuant to section 26-2-119, or aid to the blind pursuant to section 26-2-120. To be eligible for a home care allowance, a person's monthly gross income shall be less than the applicable monthly grant standard for the old age pension, aid to the needy disabled, or aid to the blind programs, plus the person's authorized monthly home care allowance grant, as determined in accordance with rules promulgated pursuant to this paragraph (b). The payments allow recipients who are in need of long-term care to purchase community-based services as defined in section 26-4-507 (2) (c). Such services may include, but need not be limited to, the supervision of self-administered medications, assistance with activities of daily living as defined in section 26-4-507 (2) (a), and

assistance with instrumental activities of daily living as defined in section 26-4-507 (2) (g). The rules adopted by the ~~department of health care policy and financing~~ MEDICAL SERVICES BOARD shall specify, in accordance with the provisions of this section, the services available under the program and shall ~~address~~ SPECIFY eligibility criteria for the home care allowance program, which shall be in addition to the eligibility criteria for the old age pension, aid to the needy disabled, or aid to the blind programs. In addition, the rules shall specifically provide for a determination as to the person's functional impairment AND the person's unmet need for paid care and shall address amounts awarded to persons eligible for home care allowance. The ~~rules shall require that~~ MEDICAL SERVICES BOARD SHALL SPECIFY IN THE RULES THE METHODS FOR DETERMINING THE UNMET NEED FOR PAID CARE AND THE AMOUNT OF A HOME CARE ALLOWANCE THAT MAY BE AWARDED TO ELIGIBLE PERSONS. SUCH METHODS MAY BE BASED ON HOW OFTEN A PERSON EXPERIENCES UNMET NEED FOR PAID CARE OR ANY OTHER METHOD THAT THE MEDICAL SERVICES BOARD DETERMINES IS VALID IN CORRELATING UNMET NEED FOR PAID CARE WITH AN AMOUNT OF A HOME CARE ALLOWANCE AWARD. THE MEDICAL SERVICES BOARD SHALL REQUIRE THAT eligibility AND UNMET NEED FOR PAID CARE be determined through the use of a comprehensive and uniform client assessment instrument as ~~defined~~ DESCRIBED in section 26-4-507. The medical services board ~~in the department of health care policy and financing~~ may adjust income eligibility criteria, ~~the~~ INCLUDING ANY functional impairment standard, or the amounts awarded to eligible persons or may limit or suspend enrollments as necessary to manage the home care allowance program within the funds appropriated by the general assembly. In addition, the medical services board ~~in the department of health care policy and financing~~ may adjust which services are available under the program; except that such adjustment shall be consistent with the provisions of this subsection (1).

(c) THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING IS AUTHORIZED TO IMPLEMENT PILOT PROGRAMS THAT IT DEEMS FEASIBLE TO ASSESS THE OVERALL IMPACT, IF ANY, OF USING ALTERNATIVES TO THE METHOD DESCRIBED IN PARAGRAPH (b) OF THIS SUBSECTION (1) FOR DETERMINING AN ELIGIBLE PERSON'S UNMET NEED FOR PAID CARE AND THE AMOUNT OF A HOME CARE ALLOWANCE AWARDED TO AN ELIGIBLE PERSON. IF NECESSARY FOR THE IMPLEMENTATION OF THIS PARAGRAPH (c), THE DEPARTMENT SHALL SEEK WAIVERS FROM THE FEDERAL GOVERNMENT IN CONNECTION WITH ANY PROGRAMS RELATED TO THE HOME CARE ALLOWANCE PROGRAM.

SECTION 5. 26-4-103 (10), (11.5), and (21), Colorado Revised Statutes, 1989 Repl. Vol., as amended, are amended, and the said 26-4-103 is further amended BY THE ADDITION OF A NEW SUBSECTION, to read:

26-4-103. Definitions. As used in this article, unless the context otherwise requires:

(10) "Medical assistance" means payment on behalf of recipients to ~~vendors~~ ENROLLED PROVIDERS UNDER THE STATE MEDICAL ASSISTANCE PROGRAM of medical care, services, goods, and devices rendered or provided TO recipients under this article, and other related payments, pursuant to this article and the rules and regulations of the state department.

(11.5) "Overpayment" means the amount paid by an agency administering the medical assistance program to a ~~vendor~~ AN ENROLLED PROVIDER UNDER THE STATE MEDICAL ASSISTANCE PROGRAM participating in the program, which amount is in excess of the amount that is allowable for services furnished and which is required by Title XIX of the ~~federal "Social Security Act"~~ SOCIAL SECURITY ACT to be refunded to the appropriate medicaid agencies.

(13.5) "PROVIDER" MEANS ANY PERSON, PUBLIC OR PRIVATE INSTITUTION, AGENCY, OR BUSINESS CONCERN PROVIDING MEDICAL CARE, SERVICES, OR GOODS AUTHORIZED UNDER THIS ARTICLE AND HOLDING, WHERE APPLICABLE, A CURRENT VALID LICENSE OR CERTIFICATE TO PROVIDE SUCH SERVICES OR TO DISPENSE SUCH GOODS AND ENROLLED UNDER THE STATE MEDICAL ASSISTANCE PROGRAM. THESE SERVICES MUST BE PROVIDED AND GOODS MUST BE DISPENSED ONLY IF PERFORMED, REFERRED, OR ORDERED BY A DOCTOR OF MEDICINE OR A DOCTOR OF OSTEOPATHY. SERVICES OF DENTISTS, PODIATRISTS, AND OPTOMETRISTS NEED NOT BE REFERRED OR ORDERED BY A DOCTOR OF MEDICINE OR A DOCTOR OF OSTEOPATHY.

(21) ~~"Vendor" means any person, public or private institution, agency, or business concern providing medical care, services, or goods authorized under this article, holding, where applicable, a current valid license to provide such services or to dispense such goods. These services must be provided and goods must be dispensed only if performed, referred, or ordered by a doctor of medicine or a doctor of osteopathy. Services of dentists, podiatrists, and optometrists need not be referred or ordered by a doctor of medicine or a doctor of osteopathy.~~

SECTION 6. 26-4-403 (1) (a) (I), the introductory portion to 26-4-403 (2) and 26-4-403 (2) (a), (2) (b), (2) (c), and (2) (e), Colorado Revised Statutes, 1989 Repl. Vol., as amended, are amended to read:

26-4-403. Recoveries - overpayments - penalties - interest - adjustments - liens. (1) (a) (I) Except as provided in section 26-4-403.3, no recipient or estate of the recipient shall be liable for the cost or the cost remaining after payment by medicaid, medicare, or a private insurer of medical benefits authorized by Title XIX of the social security act, by this title, or by rules promulgated by the medical services board, which benefits are rendered to the recipient by a provider of medical services authorized to render such service in the state of Colorado, except those contributions required pursuant to section 26-4-518 (1). However, a recipient may enter into a documented agreement with a ~~vendor~~ PROVIDER under which the recipient agrees to pay for items or services that are

nonreimbursable under the medical assistance program. Under these circumstances, a recipient is liable for the cost of such services and items.

(2) Any overpayment to a ~~vendor~~ PROVIDER, including those of personal needs funds made pursuant to section 26-4-504, shall be recoverable ~~in the following manner~~ REGARDLESS OF WHETHER THE OVERPAYMENT IS THE RESULT OF AN ERROR BY THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING, A COUNTY DEPARTMENT OF SOCIAL SERVICES, AN ENTITY ACTING ON BEHALF OF EITHER DEPARTMENT, OR BY THE PROVIDER OR ANY AGENT OF THE PROVIDER AS FOLLOWS:

(a) (I) If THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING MAKES a

determination ~~is made~~ that such overpayment has been made as a result of the ~~vendor's~~ PROVIDER'S false representation, ~~or willful failure to disclose a material fact or defalcation,~~ the state department may collect ~~one and one-half times~~ the overpayment, plus A CIVIL MONETARY PENALTY EQUAL TO ONE-HALF THE AMOUNT OF THE OVERPAYMENT, AND INTEREST ON THE SUM OF THE TWO AMOUNTS accruing at the statutory rate from the date the overpayment is identified, by the means specified in this subsection (2). Such sum may be collected for up to the amount of time prescribed in section 13-80-103.5, C.R.S., after the overpayment is identified. Amounts remaining uncollected for more than the time period prescribed in section 13-80-103.5, C.R.S., after the last repayment was made may be considered uncollectible. FOR THE PURPOSES OF THIS SUBPARAGRAPH (I), "FALSE REPRESENTATION" MEANS AN INACCURATE STATEMENT THAT IS RELEVANT TO A CLAIM FOR REIMBURSEMENT AND IS MADE BY A PROVIDER WHO HAS ACTUAL KNOWLEDGE OF THE TRUTH OF FALSE NATURE OF THE STATEMENT OR BY A PROVIDER ACTING IN DELIBERATE IGNORANCE OF OR WITH RECKLESS DISREGARD FOR THE TRUTH OF THE STATEMENT. A PROVIDER ACTS WITH RECKLESS DISREGARD FOR TRUTH IF THE PROVIDER FAILS TO MAINTAIN RECORDS REQUIRED BY THE DEPARTMENT OR IF THE PROVIDER FAILS TO BECOME FAMILIAR WITH RULES, MANUALS, AND BULLETINS ISSUED BY THE DEPARTMENT, BOARD, OR THE DEPARTMENT'S FISCAL AGENT.

(II) If the state department makes a determination that such overpayment has been made for some other reason than ~~the fraud or defalcation~~ A FALSE REPRESENTATION by the ~~vendor~~ PROVIDER specified in subparagraph (I) of this paragraph (a), the state department may collect the amount of overpayment, plus interest accruing at the statutory rate from the date the ~~vendor~~ PROVIDER is notified of such overpayment, by the means specified in this subsection (2). Pursuant to the criteria established in rules and regulations promulgated by the medical services board, the state department may waive the recovery or adjustment of all or part of the overpayment and accrued interest specified in this subparagraph (II) if it would be inequitable, uncollectible, or administratively impracticable. Amounts remaining uncollected for more than five years after the last repayment was made may be considered uncollectible.

(b) In order to collect the amounts specified in paragraph (a) of this subsection (2), the state department may withhold subsequent payments to which the ~~vendor~~ PROVIDER is or becomes entitled and apply the amount withheld as an offset. The medical services board shall establish in rules the rate at which an overpayment may be offset, with provision for a reduction of such rate upon a good cause shown by the ~~vendor~~ PROVIDER that the rate at which payment will be withheld will result in an undue hardship for the ~~vendor~~ PROVIDER. In determining whether to grant a good cause reduction, the state department shall consider the impact of collecting the amount provided by medical services board rules on the quality of patient care and the financial viability of the provider. The state department may also take such other steps administratively as are available for the collection of the amounts specified in paragraph (a) of this subsection (2).

(c) If a ~~vendor~~ PROVIDER defaults on repayment of the amounts specified in paragraph (a) of this subsection (2), the state department may bring a suit against the ~~vendor~~ PROVIDER in the appropriate court. Court costs shall not be assessed against the state department but shall be assessed against the ~~vendor~~ PROVIDER if the court finds in favor of the state department. Any costs collected by the state department shall be paid into the registry of the court. Once the amount has been reduced to

judgment, the state department may proceed with all available postjudgment remedies.

(e) Any ~~vendor~~ PROVIDER adversely affected by actions taken pursuant to this subsection (2), except when a suit is filed against the ~~vendor~~ PROVIDER pursuant to paragraph (c) of this subsection (2), may appeal the determination of the state department pursuant to the provisions in section 24-4-105, C.R.S.

SECTION 7. 26-4-403, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

26-4-403. Recoveries - overpayments - penalties - interest - adjustments - liens. (11) (a) AN ENTITY THAT ADMINISTERS A MANAGED CARE PLAN QUALIFIED PURSUANT TO SECTION 26-4-301.3 THAT HAS ENTERED INTO A RISK CONTRACT WITH THE STATE DEPARTMENT SHALL HAVE THE SAME RIGHTS OF THE DEPARTMENT SET FORTH IN THIS SECTION EXCEPT WITH RESPECT TO THE RIGHTS DESCRIBED IN SUBSECTIONS (4) AND (5) OF THIS SECTION. IN ADDITION, THE ATTORNEY GENERAL MAY NOT ENFORCE THE RIGHTS SET FORTH IN THIS SUBSECTION (11). VENUE FOR AN ACTION BROUGHT BY OR ON BEHALF OF AN ENTITY PURSUANT TO THIS SUBSECTION (11) SHALL BE GOVERNED BY THE COLORADO RULES OF CIVIL PROCEDURE.

(b) WITHIN FIFTEEN DAYS AFTER FILING AN ACTION OR ASSERTING A CLAIM AGAINST A THIRD PARTY, A RECIPIENT UNDER A MANAGED CARE PLAN OR A GUARDIAN, EXECUTOR, ADMINISTRATOR, OR OTHER APPROPRIATE REPRESENTATIVE OF THE RECIPIENT SHALL PROVIDE TO THE ENTITY THAT ADMINISTERS THE MANAGED CARE PLAN WRITTEN NOTICE OF THE ACTION OR CLAIM. NOTICE SHALL BE BY PERSONAL SERVICE OR CERTIFIED MAIL.

(c) IN CASES WHERE THE STATE DEPARTMENT HAS RECOVERY RIGHTS AGAINST A THIRD PARTY PURSUANT TO SUBSECTIONS (3) AND (4) OF THIS SECTION AND AN ENTITY THAT ADMINISTERS A MANAGED CARE PLAN HAS SUBROGATION RIGHTS AGAINST THE SAME PARTY PURSUANT TO PARAGRAPH (a) OF THIS SUBSECTION (11), THE RECOVERY RIGHTS OF THE STATE DEPARTMENT SHALL TAKE PRECEDENCE OVER THE RIGHTS OF THE MANAGED CARE PLAN.

SECTION 8. 26-4-410 (1) (a) (I), (1) (b), (1) (c), (2) (c) (II) (B), (2) (c.5), and (3), Colorado Revised Statutes, 1989 Repl. Vol., as amended, are amended to read:

26-4-410. Providers - nursing facility - nursing facility patient program improvement fund - reimbursement - maximum allowable - quality of care incentive payment program - repeal. (1) (a) (I) For the purpose of making payments to private, nonprofit, or proprietary nursing facility ~~vendors~~ PROVIDERS and intermediate care facilities for the mentally retarded, the state department shall establish a price schedule to be readjusted every twelve months, which shall reimburse, subject to available appropriations, each such ~~vendor~~ PROVIDER, as nearly as possible, for its actual or reasonable cost of services rendered, whichever is less, and a fair rental allowance for capital-related assets as defined in section 26-4-503 (4). The state department shall adopt rules and regulations, including uniform accounting or reporting procedures, in order to determine such actual or reasonable cost and the reimbursement therefor. The provisions of this subparagraph (I) shall not apply to state-operated intermediate care facilities for the mentally retarded.

(b) No ~~vendor~~ PROVIDER payment under paragraph (a) of this subsection (1) made on or after July 1, 1985, shall be lower than the ~~vendor~~ PROVIDER payment in effect on June 30, 1985, solely as a result of a payment of a fair rental allowance for capital-related assets. For the fiscal year 1986-87 and thereafter, that portion of a ~~vendor~~ PROVIDER payment required by this paragraph (b) shall be reduced by fifty percent.

(c) On and after July 1, 1987, if a ~~vendor~~ PROVIDER payment under paragraph (a) of this subsection (1) is greater than the ~~vendor~~ PROVIDER payment in effect on June 30, 1985, and such increase is wholly or partly the result of the payment of a fair rental allowance for capital-related assets, then that portion of the increase in the ~~vendor~~ PROVIDER payment attributable to the payment of a fair rental allowance for capital-related assets shall be reduced by fifty percent.

(2) (c) The medical services board shall adopt rules and regulations to:

(II) (B) Determine and pay to nursing facility ~~vendors~~ PROVIDERS a reasonable share of the amount by which the reasonable costs of the categories of administration, property, and room and board, excluding food costs, exceed the actual cost in these categories only of each facility ~~vendor~~ PROVIDER. Such reasonable share shall be defined as twelve and one-half percent of such amount in such categories for each facility, not to exceed twelve percent of the reasonable cost. As used in this sub-subparagraph (B), "nursing facility ~~vendor~~ PROVIDER" shall have the same meaning as set forth in subparagraph (VII) of paragraph (c.5) of subsection (2) of this section.

(c.5) (I) There is hereby established a quality of care incentive payment program for the purpose of encouraging improvement in the quality of care provided by nursing facility ~~vendors~~ PROVIDERS. The sum of all incentive payments made under the program shall be equal to the aggregate sum of payments made to all nursing facility ~~vendors~~ PROVIDERS under sub-subparagraph (B) of subparagraph (II) of paragraph (c) of this subsection (2).

(II) Beginning January 1, 1995, the department shall issue incentive payments under the program to nursing facility ~~vendors~~ PROVIDERS that meet the criteria established by the department through rules and regulations. In determining which ~~vendors~~ PROVIDERS shall be eligible to receive incentive payments, the department shall consider the following factors:

(A) Whether the ~~vendor~~ PROVIDER is delivering a high level of quality of care as measured by the number of validated and proven deficiencies on the ~~vendor's~~ PROVIDER'S last full recertification survey;

(B) Whether the ~~vendor~~ PROVIDER is meeting such other patient care standards as may be adopted by the department after considering the advice of the advisory committee created by subparagraph (VI) of this paragraph (c.5);

(C) The number of days of care provided annually under the state medical assistance program;

(D) The resident care characteristics; and

(E) The facility size and location.

(III) The department shall promulgate rules and regulations establishing the dollar amounts of incentive payments available through the program. Incentive payments may be graduated in amount in order to provide higher payments to those nursing facility ~~vendors which~~ PROVIDERS THAT provide a comparatively higher degree of quality care.

(IV) (A) For the period beginning January 1, 1995, and ending June 30, 1995, the department shall assess all nursing facility ~~vendors~~ PROVIDERS in accordance with the criteria adopted pursuant to subparagraph (II) of this paragraph (c.5) for the purpose of identifying those ~~vendors~~ PROVIDERS that are eligible to receive quality incentive payments. Based on such assessment, the department shall issue quality incentive payments to a minimum of forty-five percent of all such ~~vendors~~ PROVIDERS.

(B) Beginning July 1, 1995, and on July 1 of each fiscal year thereafter, the department shall reassess all nursing facility ~~vendors~~ PROVIDERS in accordance with the criteria adopted pursuant to subparagraph (II) of this paragraph (c.5) for the purpose of identifying those ~~vendors~~ PROVIDERS that are eligible to receive quality incentive payments. Based on such assessment, the department shall issue annual quality incentive payments.

(V) In the event a nursing facility ~~vendor~~ PROVIDER is denied an incentive payment under this paragraph (c.5), the ~~vendor~~ PROVIDER shall be afforded an opportunity for a hearing in accordance with the provisions of section 24-4-105, C.R.S., as administered under section 25.5-1-107 (2), C.R.S., and the rules and regulations promulgated by the department ~~which~~ THAT govern aggrieved provider appeals of rate determinations, without first meeting the requirement of informal reconsideration by the department.

(VI) (A) There is hereby created an advisory committee of nine persons to study and make recommendations to the state department on the appropriate method of measuring a "high level of quality care" for the purpose of making payments to ~~vendors~~ PROVIDERS under this paragraph (c.5). The committee shall be appointed by the executive director of the state department and shall be composed of one representative from such department, two individuals who represent the interests of consumers, one representative of the state department of public health and environment, and one representative from the state long-term care ombudsman office. The remaining four members shall be selected from a list of nominees recommended by proprietary and nonproprietary facilities as follows: Two representatives from the long-term care facility association for proprietary facilities; and two representatives of the long-term care facility association for nonproprietary facilities. The committee members shall serve without compensation. Appointments shall be made for terms of two years. Vacancies ~~which~~ THAT occur during any term shall be filled by the executive director for the remainder of such term.

(B) This subparagraph (VI) is repealed, effective July 1, 2000. Prior to said repeal, the advisory committee shall be reviewed as provided for in section 2-3-1203, C.R.S.

(VII) As used in this paragraph (c.5), "nursing facility ~~vendor~~ PROVIDER" means a facility ~~vendor which~~ PROVIDER THAT meets the state nursing home licensing standards in section 25-1-107 (1) (l) (I) or (1) (l) (II), C.R.S., is maintained primarily for the care and treatment of inpatients under the direction of a physician, and meets the requirements in 42 U.S.C. sec. 1396d for certification as a qualified provider of nursing facility services.

(3) For the purpose of making payments for ~~vendors'~~ PROVIDERS' services, the rules and regulations established by the state department shall provide that, in the determination of reasonable compensation, the criteria provided under Title XVIII of the social security act shall be taken into consideration. The state has authority to implement prospective rate reimbursement for ~~vendors~~ PROVIDERS where appropriate; EXCEPT THAT THE STATE DEPARTMENT IS AUTHORIZED TO PASS PAYMENTS THROUGH TO NURSING FACILITY PROVIDERS IN ADVANCE OF PROVIDERS' IMPLEMENTATION OF THE AUTOMATED MINIMUM DATA-SET SYSTEM, IN ACCORDANCE WITH THE FEDERAL "OMNIBUS BUDGET RECONCILIATION ACT OF 1987". The state department shall not arbitrarily discriminate between physicians and optometrists who provide similar services, goods, and prosthetic devices in the field of vision care within the scope of their respective practices, as defined by state law.

SECTION 9. 26-4-518 (1), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

26-4-518. Payments by third parties - copayments by recipients. (1) (a) Any recipient receiving benefits under this article who receives any supplemental income, available for medical purposes under rules and regulations of the state department, or who receives proceeds from sickness, accident, health, or casualty insurance shall apply ~~such~~ THE supplemental income to the cost of the benefits rendered, and the rules and regulations may require reports from ~~vendors~~ PROVIDERS of other payments received by them from or on behalf of recipients.

(b) Subject to any limitations imposed by Title XIX, a recipient shall be required to pay at the time of service a portion of the cost of any medical benefit rendered to him or to his dependents pursuant to this article, as determined by rule or regulation of the state department.

SECTION 10. 26-4-519 (7), (8), (9), and (13), Colorado Revised Statutes, 1989 Repl. Vol., as amended, are amended, and the said 26-4-519 is further amended BY THE ADDITION OF A NEW SUBSECTION, to read:

26-4-519. Program of all-inclusive care for the elderly - services - eligibility. (1.5) THE GENERAL ASSEMBLY HAS DETERMINED ON THE RECOMMENDATION OF THE STATE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING THAT THE PACE PROGRAM IS COST-EFFECTIVE. AS A RESULT OF SUCH DETERMINATION AND AFTER CONSULTATION WITH THE JOINT BUDGET COMMITTEE OF THE GENERAL ASSEMBLY, APPLICATION HAS BEEN MADE TO AND WAIVERS HAVE BEEN OBTAINED FROM THE FEDERAL HEALTH CARE FINANCING ADMINISTRATION TO IMPLEMENT THE PACE PROGRAM AS PROVIDED IN THIS SECTION. THE GENERAL ASSEMBLY, THEREFORE, AUTHORIZES THE STATE DEPARTMENT TO IMPLEMENT THE PACE PROGRAM IN ACCORDANCE WITH THIS SECTION. IN CONNECTION WITH THE IMPLEMENTATION OF

THE PROGRAM, THE STATE DEPARTMENT SHALL:

(a) PROVIDE A SYSTEM FOR REIMBURSEMENT FOR SERVICES TO THE PACE PROGRAM PURSUANT TO THIS SECTION;

(b) DEVELOP AND IMPLEMENT A CONTRACT WITH THE NONPROFIT ORGANIZATION PROVIDING THE PACE PROGRAM THAT SETS FORTH CONTRACTUAL OBLIGATIONS FOR THE PACE PROGRAM, INCLUDING BUT NOT LIMITED TO REPORTING AND MONITORING OF UTILIZATION OF SERVICES AND OF THE COSTS OF THE PROGRAM AS REQUIRED BY THE STATE DEPARTMENT;

(c) ACKNOWLEDGE THAT IT IS PARTICIPATING IN THE NATIONAL PACE PROJECT AS INITIATED BY CONGRESS;

(d) BE RESPONSIBLE FOR CERTIFYING THE ELIGIBILITY FOR SERVICES OF ALL PACE PROGRAM PARTICIPANTS.

(7) ~~Upon receipt of federal waivers, the state department shall implement the PACE program as a demonstration program to provide the services set forth in subsection (3) of this section to eligible persons, as defined in subsection (5) of this section. The demonstration program shall be implemented to provide services to eligible persons beginning on or after July 1, 1991, and shall continue until permanent waivers are granted from the federal health care financing administration, but no later than July 1, 1995. During the 1995 legislative session, the general assembly shall reexamine the PACE program and, acting by bill, determine if the program should be implemented on a permanent basis.~~

(8) Any person who accepts and receives services authorized under this section shall pay to the state department or to an agent or ~~vendor~~ PROVIDER designated by the state department an amount ~~which~~ THAT shall be the lesser of such person's gross income minus the current federal aid to needy disabled supplemental security income benefit level and cost of dependents and minus any amounts paid for private health or medical insurance, or the projected cost of services to be rendered to the person under the plan of care. Such amount shall be reviewed and revised as necessary each time the plan of care is reviewed. The state department shall establish a standard amount to be allowed for the costs of dependents. In determining a person's gross income, the state department shall establish, by rule, a deduction schedule to be allowed and applied in the case of any person who has incurred excessive medical expenses or other outstanding liabilities ~~which~~ THAT require payments.

(9) ~~(a) The state department of health care policy and financing shall apply in a joint application with the nonprofit organization providing the PACE program to the federal health care financing administration for those medicaid and medicare waivers necessary to implement the PACE program set forth in this section. Application for the waivers shall be made only if the state department determines from the evaluation specified in paragraph (b) of this subsection (9) that the PACE program is cost-effective. Prior to any application to the federal health care financing administration for waivers to implement the PACE program, the state department of health care policy and financing shall consult with the joint budget committee.~~

~~(b) The state department shall contract with an agency with health services~~

~~evaluation experience for evaluations of the PACE program, including whether the program is cost-effective. The state department shall present to the general assembly reports based on such evaluations prior to submitting the joint application for waivers on or before November 1, 1994.~~

~~(c) The state department shall provide a system for reimbursement for services to the PACE program pursuant to this section.~~

~~(d) The state department shall develop and implement a contract with the nonprofit organization providing the PACE program which sets forth contractual obligations for the PACE program, including but not limited to reporting and monitoring of utilization of costs of the program as required by the state department.~~

~~(e) The state department acknowledges that it is participating in the national PACE project as initiated by congress.~~

~~(f) The state department shall be responsible for certifying the eligibility for services of all PACE program participants.~~

(13) ~~Unless extended by the general assembly, this section shall be repealed, effective July 1, 1995. The authorization of any FTE's that may have been added to implement the pilot project authorized in this section shall be repealed upon the completion of the pilot project.~~

SECTION 11. 26-4-527, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

26-4-527. Residential child health care - waiver - program. (1) The department of health care policy and financing shall ~~conduct a feasibility study to determine whether~~ IMPLEMENT a program concerning residential child health care under this article to provide services to medicaid-eligible children RESIDING in ~~foster care~~ RESIDENTIAL CHILD CARE FACILITIES. ~~would be cost-effective.~~ The ~~feasibility study~~ MEDICAL SERVICES BOARD shall establish the type of rehabilitative or medical assistance services to be provided under the program as described in subsection (3) of this section, TO THE EXTENT SUCH SERVICES ARE COST-EFFICIENT, AND the recipient eligibility criteria ~~which~~ THAT may include, BUT ARE NOT LIMITED TO, a medical necessity determination and a financial eligibility determination. ~~and the cost-effectiveness of such a program. The department of health care policy and financing shall submit a report on cost-effectiveness, program design, and projected savings of the program to the general assembly on or before July 1, 1992.~~

(2) The department of health care policy and financing ~~is authorized to seek a waiver or an amendment to an existing waiver, if necessary, from the federal department of health and human services which would allow the department to~~ MAY limit the number of recipients or providers participating in the program IN ACCORDANCE WITH ANY FEDERAL WAIVER OBTAINED BY THE STATE DEPARTMENT TO IMPLEMENT THIS SECTION.

(3) ~~If a determination is made by the department of health care policy and financing based on the feasibility study required in subsection (1) of this section, that a residential child health care program would be cost-effective, and if all necessary~~

~~federal waivers are obtained, the department shall establish a residential child health care program under this article.~~ The department of health care policy and financing shall promulgate rules as necessary for the implementation of the program, including, but not limited to, rules regarding program services ~~which~~ THAT may include rehabilitative services as appropriate to residential child health care when referred by a physician licensed pursuant to article 36 of title 12, C.R.S., a psychologist licensed pursuant to part 3 of article 43 of title 12, C.R.S., a clinical social worker licensed pursuant to part 4 of article 43 of title 12, C.R.S., a marriage and family therapist licensed pursuant to part 5 of article 43 of title 12, C.R.S., or a professional counselor licensed pursuant to part 6 of article 43 of title 12, C.R.S.; the number of recipients participating; eligibility criteria including financial eligibility criteria; reimbursement of providers; and such other rules as are necessary for the implementation and administration of the program. The twenty percent county contribution established in section 26-1-122 for residential child care facilities may be used by the state to obtain federal financial participation under Title XIX of the ~~federal "Social Security Act"~~ SOCIAL SECURITY ACT for any residential child health care program established pursuant to this section. ~~Said~~ THE twenty percent contribution shall not be increased due to any federal financial participation received as a result of any programs established pursuant to this section. Nothing in this section shall be construed to prohibit an adjustment in the county contribution due to caseload or service cost increases. Nothing in this section shall be construed to create a county obligation to directly participate in the financing of any program established pursuant to the "Colorado Medical Assistance Act" as set forth in this article. ~~The program shall terminate on July 1, 1995, unless extended by the general assembly. If the program is implemented, the department of health care policy and financing shall submit a report on the cost-effectiveness of continuing said program to the general assembly on or before January 1, 1995.~~

(4) ~~Prior to the submittal of any waiver or amendment to an existing waiver pursuant to subsection (2) of this section, the department of health care policy and financing shall consult with the joint budget committee of the general assembly concerning the proposed number of recipients to be served, the savings anticipated, and the costs associated with the implementation of this program.~~

(5) ~~This section is repealed, effective July 1, 1995.~~

SECTION 12. 26-4-642 (4) and (5), Colorado Revised Statutes, 1989 Repl. Vol., as amended, are repealed as follows:

26-4-642. Definitions. In addition to the definitions in section 26-4-603, as used in this subpart 3, unless the context otherwise requires:

(4) ~~"Hospice services" means a comprehensive program of palliative and supportive medical services for persons who are terminally ill. Hospice services may be provided in the individual's home on a routine or continuous basis. Such services are provided within a continuum of inpatient care and home care.~~

(5) ~~"Intensive supervision for foster care children with AIDS or ARC" means services provided by specially trained providers of care who provide twenty-four-hour care and supervision to foster care children with AIDS or ARC, as defined in this section, in a child-centered, family-like setting.~~

SECTION 13. 26-4-645 (1), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

26-4-645. Services for long-term-care eligible persons. (1) Subject to the provisions of this subpart 3, the home and community-based services program for persons with AIDS or ARC shall include the following continuum of long-term care services:

(a) (Deleted by amendment, L. 93, p. 1067, 14, effective June 3, 1993.)

(b) Personal care and homemaker services;

(c) (Deleted by amendment, L. 93, p. 1067, 14, effective June 3, 1993.)

(d) Adult day care services;

(e) (Deleted by amendment, L. 93, p. 1067, 14, effective June 3, 1993.)

(f) Private duty nursing services;

(g) ~~Intensive supervision for foster care children with AIDS or ARC, which shall include the provision of medical supplies.~~

(h) ELECTRONIC MONITORING SERVICES AS SUCH TERM IS DEFINED IN SECTION 26-4-603 (9);

(i) NONMEDICAL TRANSPORTATION SERVICES AS SUCH TERM IS DEFINED IN SECTION 26-4-603 (15).

SECTION 14. 25-4-902, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

25-4-902. Immunization prior to attending school. (1) Except as provided in section 25-4-903, no child shall attend any school in the state of Colorado on or after the dates specified in section 25-4-906 (4) unless such child can present ONE OF THE FOLLOWING to the appropriate official of the school:

(a) A certificate of immunization from a licensed physician or authorized representative of the department of public health and environment or local health department stating that such child has received immunization against communicable diseases as specified by the state board of health, ~~or~~ BASED ON RECOMMENDATIONS OF THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES OR THE AMERICAN ACADEMY OF PEDIATRICS;

(b) A written authorization signed by one parent or guardian or AN AUTHORIZATION SIGNED BY the emancipated child requesting that local health officials administer the immunizations; or

(c) A plan signed by one parent or guardian or the emancipated child ~~for receipt~~

~~by~~ DEMONSTRATING THAT REQUIRED IMMUNIZATIONS FOR the child ~~of the required inoculation or the first or the next required of a series of inoculations~~ WILL BEGIN OR WILL BE RESUMED within thirty days FROM THE DATE THE PLAN WAS SIGNED.

SECTION 15. 25.5-1-201 (1), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended by THE ADDITION OF A NEW PARAGRAPH to read:

25.5-1-201. Programs to be administered by the department of health care policy and financing. (1) Programs to be administered and functions to be performed by the department of health care policy and financing shall be as follows:

(i) EFFECTIVE JULY 1, 1996, SCHOOL ENTRY IMMUNIZATION, AS SPECIFIED IN PART 9 OF ARTICLE 4 OF TITLE 25, C.R.S., COMMENCING ON AND AFTER THE FISCAL YEAR BEGINNING JULY 1, 1996, THE STATE DEPARTMENT IS AUTHORIZED TO CONTRACT WITH THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT FOR THE PURPOSE OF ENFORCING THE SCHOOL ENTRY IMMUNIZATION REQUIREMENTS.

SECTION 16. 26-4-528, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

26-4-528. Managed mental health services feasibility study - waiver - pilot program. (1) (a) The department of health care policy and financing and the department of human services shall jointly conduct a feasibility study concerning management of mental health services under the "Colorado Medical Assistance Act", which study shall consider a prepaid capitated ~~single entry point~~ system for providing comprehensive mental health services. In conducting the study, the department of health care policy and financing and the department of human services shall:

(I) Consult with knowledgeable and concerned persons in the state, including low-income persons who are recipients of mental health services and providers of mental health services under the "Colorado Medical Assistance Act"; and

(II) Consider the effect of any program on the provider or community mental health centers and clinics. Any prepaid capitated ~~single entry point~~ program shall, as much as possible, avoid exposing providers or community mental health centers and clinics to undue financial risk or reliance on supplemental revenues from state general funds, local revenues, or fee-for-service funds.

(b) On or before October 1, 1992, the state department and the department of human services shall provide a written report to the general assembly assessing the costs, benefits, risks, alternatives, and impact upon recipients, providers, and mental health services in this state, for each model or proposed program modification. Said report shall include recommendations for implementation of any model or proposed program modification.

(2) The state department is authorized to seek a waiver of the requirements of Title XIX of the social security act to allow the state department to limit a recipient's freedom of choice of providers and to restrict reimbursement for mental health services to designated and contracted agencies.

(3) (a) If a determination is made by the department of health care policy and

financing and the department of human services, based on the feasibility study required in subsection (1) of this section, that the implementation of one or more model or proposed program modifications would be cost-effective, and if all necessary federal waivers are obtained, the department of health care policy and financing shall establish a pilot prepaid capitated ~~single entry point~~ system for providing comprehensive mental health services. The department of health care policy and financing shall promulgate rules as necessary for the implementation and administration of the pilot program. The pilot program shall terminate on ~~July 1, 1996, unless extended by the general assembly~~ JULY 1, 1997. If the pilot program is implemented, the department of health care policy and financing and the department of human services shall submit to the general assembly on or before ~~January 1, 1996,~~ JULY 1, 1996, a PRELIMINARY STATUS report on the ~~cost-effectiveness of continuing said~~ PILOT program.

(b) IN ADDITION TO THE PRELIMINARY REPORT DESCRIBED IN PARAGRAPH (a) OF THIS SUBSECTION (3), THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING AND THE DEPARTMENT OF HUMAN SERVICES SHALL SUBMIT A FINAL REPORT TO THE GENERAL ASSEMBLY NO LATER THAN JANUARY 1, 1997, ADDRESSING THE FOLLOWING:

(I) AN ASSESSMENT OF THE PILOT PROGRAM COSTS, ESTIMATED COSTS SAVINGS, BENEFITS TO RECIPIENTS, RECIPIENT ACCESS TO MENTAL HEALTH SERVICES, AND THE IMPACT OF THE PROGRAM ON RECIPIENTS, PROVIDERS, AND THE STATE MENTAL HEALTH SYSTEM;

(II) RECOMMENDATIONS CONCERNING THE FEASIBILITY OF PROCEEDING WITH A PREPAID CAPITATED SYSTEM OF COMPREHENSIVE MENTAL HEALTH SERVICES ON A STATEWIDE BASIS;

(III) RECOMMENDATIONS RESULTING FROM CONSULTATION WITH LOCAL CONSUMERS, FAMILY MEMBERS OF RECIPIENTS, PROVIDERS OF MENTAL HEALTH SERVICES, AND LOCAL HUMAN SERVICES AGENCIES;

(IV) RECOMMENDATIONS CONCERNING THE ROLE OF COMMUNITY MENTAL HEALTH CENTERS UNDER THE PREPAID CAPITATED SYSTEM, INCLUDING PLANS TO PROTECT THE INTEGRITY OF THE STATE MENTAL HEALTH SYSTEM AND TO ENSURE THAT COMMUNITY MENTAL HEALTH PROVIDERS ARE NOT EXPOSED TO UNDUE FINANCIAL RISKS UNDER THE PREPAID CAPITATED SYSTEM. THIS SUBPARAGRAPH (IV) IS BASED ON THE UNIQUE AND HISTORICAL ROLE THAT COMMUNITY MENTAL HEALTH CENTERS HAVE ASSUMED IN MEETING THE MENTAL HEALTH NEEDS OF COMMUNITIES THROUGHOUT THE STATE.

(4) ~~This section is repealed, effective July 1, 1996.~~

(5) THE GENERAL ASSEMBLY FINDS THAT PRELIMINARY INDICATIONS FROM OTHER STATES SHOW THAT PREPAID CAPITATED SYSTEMS FOR PROVIDING MENTAL HEALTH SERVICES TO MEDICAL ASSISTANCE RECIPIENTS RESULT IN COST-SAVINGS TO THE STATE. THE GENERAL ASSEMBLY, THEREFORE, DECLARES IT APPROPRIATE TO AMEND SUBSECTIONS (1), (3), AND (4) OF THIS SECTION AND TO ENACT THIS SUBSECTION (5) AND SUBSECTIONS (6) TO (9) OF THIS SECTION.

(6) ON OR BEFORE JANUARY 1, 1997, THE DEPARTMENT OF HEALTH CARE POLICY

AND FINANCING SHALL SEEK THE NECESSARY WAIVERS TO IMPLEMENT THE SYSTEM STATEWIDE. NO LATER THAN JULY 1, 1997, OR NINETY DAYS AFTER RECEIPT OF THE NECESSARY FEDERAL WAIVERS, WHICHEVER OCCURS LATER, THE DEPARTMENT OF HUMAN SERVICES, IN COOPERATION WITH THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING, SHALL BEGIN TO IMPLEMENT ON A STATEWIDE BASIS A PREPAID CAPITATED SYSTEM FOR PROVIDING COMPREHENSIVE MENTAL HEALTH SERVICES TO RECIPIENTS UNDER THE STATE MEDICAL ASSISTANCE PROGRAM. THE PREPAID CAPITATED SYSTEM SHALL BE FULLY IMPLEMENTED NO LATER THAN JANUARY 1, 1998, OR SIX MONTHS AFTER RECEIPT OF THE NECESSARY WAIVERS, WHICHEVER OCCURS LATER. THE WAIVER REQUEST SHALL BE CONSISTENT WITH THE REPORT SUBMITTED TO THE GENERAL ASSEMBLY IN ACCORDANCE WITH SUBSECTION (3) OF THIS SECTION.

(7) THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING, IN COOPERATION WITH THE DEPARTMENT OF HUMAN SERVICES, SHALL REVISE THE WAIVER REQUEST OBTAINED PURSUANT TO SUBSECTION (2) OF THIS SECTION OR, IF NECESSARY, SHALL SUBMIT A NEW WAIVER REQUEST THAT ALLOWS THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING TO LIMIT A RECIPIENT'S FREEDOM OF CHOICE WITH RESPECT TO A PROVIDER OF MENTAL HEALTH SERVICES AND TO RESTRICT REIMBURSEMENTS TO MENTAL HEALTH SERVICES PROVIDERS. THIS WAIVER REQUEST OR AMENDMENT SHALL BE CONSOLIDATED WITH THE WAIVER DESCRIBED IN SUBSECTION (6) OF THIS SECTION.

(8) NO LATER THAN MAY 1, 1997, OR SIXTY DAYS AFTER RECEIPT OF THE NECESSARY FEDERAL WAIVERS DESCRIBED IN SUBSECTIONS (6) AND (7) OF THIS SECTION, WHICHEVER OCCURS LATER, THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING SHALL PROPOSE RULES TO THE MEDICAL SERVICES BOARD FOR THE IMPLEMENTATION OF THE PREPAID CAPITATED SINGLE ENTRY POINT SYSTEM FOR MENTAL HEALTH SERVICES.

(9) THE IMPLEMENTATION OF THIS SUBSECTION (9) AND SUBSECTIONS (5) TO (8) OF THIS SECTION IS CONDITIONED UPON THE RECEIPT OF NECESSARY FEDERAL WAIVERS. THE IMPLEMENTATION OF THE STATEWIDE SYSTEM SHALL CONFORM TO THE PROVISIONS OF THE FEDERAL WAIVER; EXCEPT THAT, NO LATER THAN NINETY DAYS AFTER RECEIPT OF THE FEDERAL WAIVERS, THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING SHALL SUBMIT TO THE GENERAL ASSEMBLY A REPORT THAT OUTLINES THE PROVISIONS OF THE WAIVER AND MAKES RECOMMENDATIONS FOR LEGISLATION DURING THE NEXT LEGISLATIVE SESSION THAT ASSURES STATE CONFORMANCE TO THE FEDERAL WAIVERS.

SECTION 17. Part 4 of article 4 of title 26, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SECTION to read:

26-4-414.5. Medical services provided by certified family planning clinics. (1) WHEN MEDICAL OR DIAGNOSTIC SERVICES ARE PROVIDED IN ACCORDANCE WITH THIS ARTICLE BY A CERTIFIED FAMILY PLANNING CLINIC, THE EXECUTIVE DIRECTOR OF THE STATE DEPARTMENT SHALL AUTHORIZE REIMBURSEMENT FOR THE SERVICES. THE REIMBURSEMENT SHALL BE MADE DIRECTLY TO THE CERTIFIED FAMILY PLANNING CLINIC.

(2) FOR PURPOSES OF THIS SECTION, "CERTIFIED FAMILY PLANNING CLINIC" MEANS A FAMILY PLANNING CLINIC CERTIFIED BY THE COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT, ACCREDITED BY A NATIONAL FAMILY PLANNING ORGANIZATION, AND STAFFED BY MEDICAL PROFESSIONALS LICENSED TO PRACTICE IN THE STATE OF COLORADO, INCLUDING, BUT NOT LIMITED TO, DOCTORS OF MEDICINE, DOCTORS OF OSTEOPATHY, PHYSICIANS' ASSISTANTS, AND ADVANCED PRACTICE NURSES.

(3) FOR PURPOSES OF THIS SECTION, ALL MEDICAL CARE SERVICES OR GOODS RENDERED BY A CERTIFIED FAMILY PLANNING CLINIC THAT ARE BENEFITS OF THE COLORADO MEDICAL ASSISTANCE PROGRAM SHALL BE ORDERED BY A PHYSICIAN WHO NEED NOT BE PHYSICALLY PRESENT ON THE PREMISES OF THE CERTIFIED FAMILY PLANNING CLINIC AT THE TIME SERVICES ARE RENDERED.

(4) NOTHING IN THIS SECTION SHALL BE CONSTRUED AS EXPANDING THE PROVISION OF SERVICES AVAILABLE AS A PART OF THE MEDICAL ASSISTANCE PROGRAMS ESTABLISHED PURSUANT TO THIS ARTICLE. FOR PURPOSES OF MAKING PAYMENTS TO CERTIFIED FAMILY PLANNING CLINICS PURSUANT TO THIS SECTION, THE STATE DEPARTMENT SHALL ESTABLISH RULES AND REGULATIONS IMPLEMENTING THIS SECTION. THE RULES AND REGULATIONS PROMULGATED PURSUANT TO THIS SUBSECTION (4) SHALL ENSURE THAT THE REIMBURSEMENT FOR SERVICES RENDERED BY A CERTIFIED FAMILY PLANNING CLINIC PURSUANT TO THIS SECTION SHALL NOT BE THE SOLE RESULT OF AN INCREASE IN THE COSTS TO THE STATE MEDICAL ASSISTANCE PROGRAM.

SECTION 18. 26-4-506 (2) (b) (I), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

26-4-506. Spousal protection - protection of income and resources for community spouse - definitions - amounts retained - responsibility of state department - right to appeal. (2) (b) (I) The resources available to the married couple shall be ~~divided~~ CALCULATED at the beginning of a continuous period of institutionalization of the institutionalized spouse. ~~Resources shall be divided fifty-fifty with the provision that the community spouse retain the first twelve thousand dollars in resources, up to a maximum of sixty thousand dollars (increased annually by the consumer price index for all urban consumers)~~ THE COMMUNITY SPOUSE SHALL RETAIN THE REMAINDER OF THE COUPLE'S COUNTABLE RESOURCES UP TO THE FEDERAL MAXIMUM RESOURCE ALLOWANCE as a community spouse resources allowance. THE INSTITUTIONALIZED SPOUSE MAY KEEP AN AMOUNT UP TO THE AMOUNT OF RESOURCES ALLOWED UNDER THE FEDERAL MEDICAID PROGRAM.

SECTION 19. 26-4-506.7, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is REPEALED AND REENACTED, WITH AMENDMENTS, to read:

26-4-506.7. Private-public partnership education and information program concerning long-term care insurance authorized. (1) THE GENERAL ASSEMBLY HEREBY DECLARES THAT:

(a) A LARGE NUMBER OF COLORADANS ARE IN NEED OF LONG-TERM HEALTH CARE;

(b) THE COST OF LONG-TERM CARE, ESPECIALLY NURSING HOME CARE, IS SIGNIFICANT;

(c) MANY PERSONS IN NEED OF LONG-TERM CARE ARE INELIGIBLE FOR STATE MEDICAL ASSISTANCE DUE TO COUNTABLE RESOURCES. WHEN FACED WITH THE NEED FOR LONG-TERM CARE, SUCH PERSONS EXPEND SUCH RESOURCES TO PAY FOR NURSING HOME CARE.

(d) A PERSON'S RESOURCES MAY COVER ONLY A RELATIVELY SHORT PERIOD OF CARE, OFTEN RESULTING IN RENDERING SUCH PERSON IMPOVERISHED, AND AFTER WHICH TIME THE PERSON MUST RELY ON STATE MEDICAL ASSISTANCE;

(e) EXPENDITURES FOR LONG-TERM CARE REPRESENT A SIGNIFICANT PORTION OF THE STATE'S MEDICAL ASSISTANCE BUDGET;

(f) UNLESS COLORADO IMPLEMENTS NEW METHODS FOR FINANCING LONG-TERM CARE, WHICH METHODS INCLUDE PARTICIPATION BY THE PRIVATE SECTOR, THE COST TO THE STATE FOR LONG-TERM CARE WILL INCREASE ASTRONOMICALLY; AND

(g) IT IS THEREFORE APPROPRIATE TO ENACT LEGISLATION THAT ALLOWS THE STATE DEPARTMENT, UPON A DETERMINATION BY THE EXECUTIVE DIRECTOR OF THE STATE DEPARTMENT THAT IT IS FEASIBLE, TO DESIGN AND IMPLEMENT A PRIVATE-PUBLIC PARTNERSHIP FOR FINANCING LONG-TERM CARE IN THIS STATE.

(2) THE STATE DEPARTMENT SHALL COOPERATE WITH THE DIVISION OF INSURANCE IN THE DEPARTMENT OF REGULATORY AGENCIES IN A PRIVATE-PUBLIC PARTNERSHIP FOR FINANCING LONG-TERM CARE IN THIS STATE THROUGH THE AVAILABILITY OF LONG-TERM CARE INSURANCE POLICIES THAT RESULT IN A REDUCTION OF TOTAL DEPENDENCY ON THE MEDICAL ASSISTANCE PROGRAM TO FINANCE SUCH CARE. IT IS THE GENERAL ASSEMBLY'S INTENT THAT SUCH PARTNERSHIP SHALL BE DESIGNED TO ENCOURAGE INDIVIDUALS TO PURCHASE LONG-TERM CARE INSURANCE, WHICH, WITH RESPECT TO MIDDLE TO HIGHER INCOME INDIVIDUALS, WILL HAVE THE RESULT OF ELIMINATING OR DELAYING THE INDIVIDUAL'S NEED FOR MEDICAL ASSISTANCE.

(3) UNDER THE PARTNERSHIP DESCRIBED IN SUBSECTION (2) OF THIS SECTION, THE DIVISION OF INSURANCE SHALL IMPLEMENT STATUTORY CHANGES TO ARTICLE 19 OF TITLE 10, C.R.S., CONCERNING LONG-TERM CARE POLICIES THAT THE GENERAL ASSEMBLY HEREBY DECLARES ARE NECESSARY TO ACCOMPLISH THE PURPOSE OF THE PARTNERSHIP DESCRIBED IN THIS SECTION. IN ADDITION, THE STATE DEPARTMENT IS ENCOURAGED TO IMPLEMENT A PUBLIC EDUCATION-AWARENESS PROGRAM BASED ON RECOMMENDATIONS FROM AN ADVISORY COMMITTEE THAT THE EXECUTIVE DIRECTOR OF THE STATE DEPARTMENT IS HEREBY AUTHORIZED TO ESTABLISH.

(4) THE STATE DEPARTMENT IS AUTHORIZED TO SEEK AND ACCEPT FUNDS, GRANTS, OR DONATIONS FROM ANY PRIVATE ENTITY FOR IMPLEMENTING THE PUBLIC EDUCATION-AWARENESS PROGRAM. IN ADDITION, IF NECESSARY, THE STATE DEPARTMENT MAY ASSESS A FEE IN CONNECTION WITH CONDUCTING ANY PUBLIC EDUCATION-AWARENESS TRAINING PROGRAM OR SEMINAR. ANY SUCH FEE COLLECTED SHALL BE TRANSMITTED TO THE STATE TREASURER, WHO SHALL CREDIT THE SAME TO THE LONG-TERM CARE INSURANCE FUND, WHICH FUND IS HEREBY CREATED. THE MONEYS IN THE FUND SHALL BE SUBJECT TO ANNUAL APPROPRIATION

BY THE GENERAL ASSEMBLY FOR THE SOLE PURPOSE OF PUBLIC EDUCATION-AWARENESS TRAINING PROGRAMS AND SEMINARS.

(5) IN ADDITION TO ADMINISTERING THE PUBLIC EDUCATION-AWARENESS PROGRAM UNDER THE PARTNERSHIP, THE STATE DEPARTMENT SHALL SEEK A FEDERAL WAIVER FROM THE REQUIREMENT OF SECTION 13612 OF THE FEDERAL "OMNIBUS BUDGET RECONCILIATION ACT OF 1993" (OBRA), PUBLIC LAW 103-66, THAT PREVENTS THE STATE DEPARTMENT FROM GRANTING MEDICAL ASSISTANCE APPLICANTS A FULL OR PARTIAL RESOURCE EXEMPTION IN DETERMINING ELIGIBILITY FOR MEDICAL ASSISTANCE AND AN EXEMPTION FROM ESTATE RECOVERY REQUIREMENTS.

(6) THE STATE DEPARTMENT, IF FUNDS ARE AVAILABLE, SHALL CONTRACT WITH A PUBLIC OR PRIVATE ENTITY TO CONDUCT AN EVALUATION OF THE PUBLIC EDUCATION-AWARENESS PROGRAM ON OR BEFORE DECEMBER 1, 2000. THE STATE DEPARTMENT SHALL PROVIDE A WRITTEN REPORT TO THE GENERAL ASSEMBLY BASED ON THE INDEPENDENT EVALUATION. THE REPORT SHALL INCLUDE AN ASSESSMENT OF AN INFORMATION CAMPAIGN AND THE EFFECTIVENESS OF TRAINING. IN ADDITION, THE REPORT SHALL IDENTIFY ANY COST-SAVINGS TO THE MEDICAL ASSISTANCE PROGRAM, ANY IMPACT ON THE PROGRAM AS A RESULT OF THE AVAILABILITY OF LONG-TERM CARE POLICIES, AND THE AVAILABILITY OF RESOURCE AND ESTATE RECOVERY EXEMPTIONS, WITH ANY RECOMMENDATIONS FOR LEGISLATIVE CHANGES.

(7) WITH RESPECT TO A POLICYHOLDER WHO HAS ALLOWED HIS OR HER PRIVATE LONG-TERM CARE INSURANCE POLICY TO LAPSE, IF THE PERSON IS FOUND TO BE ELIGIBLE FOR THE MEDICAL ASSISTANCE PROGRAM, THE STATE DEPARTMENT IS AUTHORIZED TO PAY THE PREMIUM FOR A REINSTATED POLICY PURSUANT TO SECTION 10-19-107 (2), C.R.S., IF THE STATE DEPARTMENT FINDS THAT TO DO SO IS FEASIBLE AND COST EFFICIENT.

SECTION 20. 10-19-103 (5), Colorado Revised Statutes, 1994 Repl. Vol., is amended, and the said 10-19-103 is further amended BY THE ADDITION OF THE FOLLOWING NEW SUBSECTIONS, to read:

10-19-103. Definitions. As used in this article, unless the context otherwise requires:

(1.5) "BASIC LONG-TERM CARE PLAN" MEANS A LONG-TERM CARE INSURANCE PLAN SUITABLE FOR SALE TO PERSONS WITH MODERATE INCOMES DEVELOPED PURSUANT TO SECTION 10-19-113.5.

(5) "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage for not less than twelve consecutive months for each covered person on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital. "Long-term care insurance" includes group and individual annuities and life insurance policies or riders ~~which~~ THAT provide directly or ~~which~~ THAT supplement long-term care insurance. THIS TERM DOES NOT INCLUDE LIFE INSURANCE POLICIES THAT ACCELERATE THE DEATH BENEFIT SPECIFICALLY FOR ONE OR MORE OF THE QUALIFYING EVENTS OF TERMINAL ILLNESS, MEDICAL CONDITIONS REQUIRING

EXTRAORDINARY MEDICAL INTERVENTION, OR PERMANENT INSTITUTIONAL CONFINEMENT AND THAT PROVIDE THE OPTION OF A LUMP-SUM PAYMENT FOR THOSE BENEFITS AND IN WHICH NEITHER THE BENEFITS NOR THE ELIGIBILITY FOR THE BENEFITS IS CONDITIONED UPON THE RECEIPT OF LONG-TERM CARE. "Long-term care insurance" also includes a policy or rider ~~which~~ THAT provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Long-term care insurance may be issued by insurers, fraternal benefit societies, nonprofit hospital, medical-surgical, and health service corporations, prepaid health plans, health maintenance organizations, or any similar organizations to the extent they are otherwise authorized to issue life or health insurance. "Long-term health care insurance" shall not include any insurance policy which is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset protection coverage, accident-only coverage, specified disease or specified accident coverage, or limited-benefit health coverage. NOTWITHSTANDING ANY OTHER PROVISIONS CONTAINED HEREIN, ANY PRODUCT ADVERTISED, MARKETED, OR OFFERED AS LONG-TERM CARE INSURANCE SHALL BE SUBJECT TO THE PROVISIONS OF THIS ARTICLE.

(7) "STANDARD LONG-TERM CARE PLAN" MEANS A LONG-TERM CARE INSURANCE PLAN SUITABLE FOR SALE TO PERSONS WITH MIDDLE OR HIGH INCOMES DEVELOPED PURSUANT TO SECTION 10-19-113.5.

SECTION 21. 10-19-107, Colorado Revised Statutes, 1994 Repl. Vol., is amended BY THE ADDITION OF A NEW SUBSECTION to read:

10-19-107. Performance standards. (2) A LONG-TERM CARE INSURANCE POLICY SHALL:

(a) OFFER THE POLICYHOLDER THE OPPORTUNITY TO DESIGNATE AN INDIVIDUAL WHO CAN BE CONTACTED IN THE EVENT THE POLICY IS ABOUT TO LAPSE. IF THE POLICYHOLDER DECLINES TO DESIGNATE SOMEONE, THE CARRIER SHALL OBTAIN A SIGNED STATEMENT THAT THE POLICYHOLDER HAS BEEN OFFERED THIS OPPORTUNITY AND DECLINED. THE POLICYHOLDER HAS THE RIGHT TO PERIODICALLY UPDATE HIS OR HER AUTHORIZED DESIGNEE.

(b) PROVIDE A NINETY-DAY REINSTATEMENT PERIOD FOR POLICYHOLDERS WHO HAVE ALLOWED THEIR POLICIES TO LAPSE DUE TO NONPAYMENT OF PREMIUM, WHO HAVE A COGNITIVE IMPAIRMENT, AND WHO HAVE REGULARLY PAID THE REQUIRED PREMIUMS. THE REINSTATED POLICY SHALL PROVIDE THE SAME BENEFITS, TERMS, AND PREMIUMS AS THE LAPSED POLICY.

SECTION 22. 10-19-108 (1), Colorado Revised Statutes, 1994 Repl. Vol., is amended to read:

10-19-108. Requirements for preexisting conditions. (1) A long-term care insurance policy or certificate, other than a policy or certificate thereunder, issued to a group as defined in section 10-19-103 (4) (a), (4) (b), or (4) (c), shall not use a definition of "preexisting condition" ~~which~~ THAT is more restrictive than the following: "Preexisting condition" means ~~the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care, or treatment or~~ a condition

for which medical advice or treatment was recommended by or received from a provider of health care services within six months preceding the effective date of coverage of an insured person.

SECTION 23. 10-19-112, Colorado Revised Statutes, 1994 Repl. Vol., is amended BY THE ADDITION OF THE FOLLOWING NEW SUBSECTIONS to read:

10-19-112. Outline of coverage - certificate. (4) WHEN A LONG-TERM CARE BENEFIT BECOMES PAYABLE BY THE ACCELERATION OF A DEATH BENEFIT, THE INSURER SHALL PROVIDE A REPORT TO THE POLICYHOLDER THAT INCLUDES THE FOLLOWING INFORMATION:

(a) ANY LONG-TERM CARE BENEFITS PAID OUT DURING THE MONTH;

(b) AN EXPLANATION OF ANY CHANGES IN BENEFITS UNDER THE POLICY DUE TO LONG-TERM CARE BENEFITS THAT HAVE BEEN PAID AS PROVIDED BY THIS SUBSECTION (4). SUCH CHANGES INCLUDE, BUT ARE NOT LIMITED TO, REMAINING DEATH BENEFITS, THE CASH VALUE OF THE POLICY, AND THE REMAINING LONG-TERM CARE BENEFITS UNDER THE POLICY.

(5) ANY HEALTH CARE OR LIFE INSURANCE POLICY OR RIDER THAT IS ADVERTISED, MARKETED, OR OFFERED AS LONG-TERM CARE OR NURSING HOME INSURANCE SHALL COMPLY WITH THE PROVISIONS OF THIS ARTICLE.

SECTION 24. Article 19 of title 10, Colorado Revised Statutes, 1994 Repl. Vol., is amended BY THE ADDITION OF THE FOLLOWING NEW SECTIONS to read:

10-19-113.3. Incontestability period. (1) WITH RESPECT TO A POLICY OR CERTIFICATE THAT HAS BEEN IN FORCE FOR LESS THAN SIX MONTHS, AN INSURER MAY RESCIND A LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE OR DENY A LONG-TERM CARE INSURANCE CLAIM UNDER SUCH A POLICY UPON A SHOWING OF MISREPRESENTATION THAT IS MATERIAL TO THE ACCEPTANCE FOR COVERAGE.

(2) WITH RESPECT TO A POLICY OR CERTIFICATE THAT HAS BEEN IN FORCE FOR AT LEAST SIX MONTHS BUT LESS THAN TWO YEARS, AN INSURER MAY RESCIND A LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE OR DENY AN OTHERWISE VALID LONG-TERM CARE INSURANCE CLAIM UPON A SHOWING OF MISREPRESENTATION THAT IS BOTH MATERIAL TO THE ACCEPTANCE FOR COVERAGE AND PERTAINS TO THE CONDITION FOR WHICH BENEFITS ARE SOUGHT. A POLICY OR CERTIFICATE THAT HAS BEEN IN FORCE FOR TWO YEARS SHALL NOT BE CONTESTED SOLELY ON THE GROUNDS OF MISREPRESENTATION. SUCH A POLICY OR CERTIFICATE MAY BE CONTESTED ONLY UPON A SHOWING THAT THE INSURED KNOWINGLY AND INTENTIONALLY MISREPRESENTED RELEVANT FACTS RELATING TO THE INSURED'S HEALTH.

(3) NO LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE MAY BE FIELD ISSUED BASED ON MEDICAL OR HEALTH STATUS. FOR PURPOSES OF THIS SUBSECTION (3), "FIELD ISSUED" MEANS A POLICY OR CERTIFICATE ISSUED BY A PRODUCER PURSUANT TO THE UNDERWRITING AUTHORITY GRANTED TO THE PRODUCER BY A CARRIER.

(4) NO BENEFIT PAYMENT MAY BE RECOVERED BY THE INSURER IN THE EVENT THAT THE POLICY OR CERTIFICATE IS RESCINDED PURSUANT TO THIS SECTION.

10-19-113.5. Requirement to offer basic and standard long-term care plans - advisory committee established. (1) EFFECTIVE JANUARY 1, 1997, EVERY CARRIER OFFERING, MARKETING, OR SELLING LONG-TERM CARE INSURANCE COVERAGE TO COLORADO RESIDENTS, AS A CONDITION OF TRANSACTING BUSINESS IN THIS STATE, SHALL ACTIVELY OFFER TO SUCH PERSONS THE CHOICE OF A BASIC LONG-TERM CARE PLAN OR A STANDARD LONG-TERM CARE PLAN IN ADDITION TO ANY OTHER PLAN OR PLANS OFFERED BY THAT CARRIER.

(2) (a) NO LATER THAN AUGUST 1, 1995, THE COMMISSIONER SHALL APPOINT A LONG-TERM CARE BENEFIT PLAN ADVISORY COMMITTEE TO RECOMMEND THE FORM AND LEVEL OF COVERAGES OF THE BASIC AND STANDARD LONG-TERM CARE PLANS. THE COMMITTEE SHALL BE COMPOSED OF REPRESENTATIVES OF LONG-TERM CARE INSURANCE CARRIERS, PURCHASERS OF LONG-TERM CARE INSURANCE POLICIES, HEALTH CARE PROVIDERS, PRODUCERS, AND THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING.

(b) THE COMMITTEE SHALL RECOMMEND BENEFIT LEVELS, COST-SHARING FACTORS, EXCLUSIONS, LIMITATIONS, AND COST CONTAINMENT FEATURES FOR THE BASIC LONG-TERM CARE PLAN AND THE STANDARD LONG-TERM CARE PLAN. THE COMMITTEE MAY DESIGN A BASIC LONG-TERM CARE PLAN AND A STANDARD LONG-TERM CARE PLAN THAT CONTAIN BENEFIT AND COST-SHARING LEVELS THAT ARE CONSISTENT WITH THE BASIC METHOD AND OPERATION OF HEALTH MAINTENANCE ORGANIZATIONS. IN ADDITION, THE COMMITTEE MAY MAKE RECOMMENDATIONS THAT INCLUDE DIFFERENT PROVISIONS FOR BOTH THE BASIC LONG-TERM CARE PLAN AND THE STANDARD LONG-TERM CARE PLAN, WHICH DIFFERENCES MAY BE BASED ON THE AGE GROUP OF PERSONS SEEKING LONG-TERM CARE INSURANCE COVERAGE.

(c) ON OR BEFORE MARCH 1, 1996, THE COMMITTEE SHALL SUBMIT ITS RECOMMENDATIONS FOR A BASIC LONG-TERM CARE PLAN AND A STANDARD LONG-TERM CARE PLAN TO THE COMMISSIONER. THE COMMISSIONER SHALL REVIEW AND APPROVE THE PLAN NO LATER THAN JULY 1, 1996. ON OR BEFORE JULY 1, 1997, AND EACH JULY 1 THEREAFTER, THE COMMITTEE, IF IT DEEMS NECESSARY, SHALL SUBMIT RECOMMENDATIONS TO THE COMMISSIONER FOR CHANGES IN THE PLANS. THE COMMISSIONER, WITHIN SIXTY DAYS AFTER THE RECEIPT OF THE SUBMITTAL, SHALL APPROVE OR DENY THE RECOMMENDATIONS.

(3) THE COMMISSIONER MAY ACCEPT FUNDS, GRANTS, OR DONATIONS FROM ANY PRIVATE ENTITY FOR THE PURPOSE OF HIRING A FULL-TIME PERSON TO ASSIST THE ADVISORY COMMITTEE IN DEVELOPING ITS RECOMMENDATIONS FOR A BASIC LONG-TERM CARE PLAN AND A STANDARD LONG-TERM CARE PLAN, TO ASSIST THE COMMISSIONER IN ADOPTING RULES IN ACCORDANCE WITH SECTION 10-19-113.7, AND TO ASSIST IN EDUCATING CARRIERS AND PRODUCERS ABOUT THE STATUTORY REQUIREMENTS CONCERNING LONG-TERM CARE POLICIES.

10-19-113.7. Rules. ON OR BEFORE JANUARY 1, 1997, THE COMMISSIONER SHALL ADOPT RULES NECESSARY TO IMPLEMENT A BASIC LONG-TERM CARE PLAN AND A STANDARD LONG-TERM CARE PLAN TO BE OFFERED BY EACH LONG-TERM CARE INSURANCE CARRIER AS A CONDITION OF TRANSACTING BUSINESS IN THIS STATE AND

RULES ESTABLISHING MINIMUM STANDARDS FOR MARKETING PRACTICES, PRODUCER COMPENSATION, PRODUCER TESTING, PENALTIES, AND REPORTING PRACTICES FOR LONG-TERM CARE INSURANCE. IN ADDITION, THE COMMISSIONER MAY ISSUE REGULATIONS TO ESTABLISH MINIMUM STANDARDS CONCERNING PREMIUM RATE STABILIZATION AND SUITABILITY.

10-19-114.5. Penalties. IN ADDITION TO ANY OTHER PENALTIES PROVIDED BY THE LAWS OF COLORADO, ANY CARRIER OR ANY PRODUCER WHO VIOLATES ANY REQUIREMENT OF COLORADO LAW RELATING TO THE REGULATION OF LONG-TERM CARE INSURANCE OR THE MARKETING OF SUCH INSURANCE SHALL BE SUBJECT TO A FINE OF UP TO THREE TIMES THE AMOUNT OF ANY COMMISSIONS PAID FOR EACH POLICY INVOLVED IN THE VIOLATION OR UP TO TEN THOUSAND DOLLARS, WHICHEVER IS GREATER.

SECTION 25. 22-82-101, Colorado Revised Statutes, 1988 Repl. Vol., as amended, is amended to read:

22-82-101. Legislative declaration. The general assembly hereby declares that the intent of this article is to determine the feasibility of operating school districts and boards of cooperative services as medical assistance ~~vendors~~ PROVIDERS, thereby making such districts eligible to obtain medicaid reimbursement for services provided to the students in the public schools, through the implementation of a pilot program in selected districts.

SECTION 26. 22-82-102 (5), Colorado Revised Statutes, 1988 Repl. Vol., as amended, is amended to read:

22-82-102. Definitions. For the purposes of this article, unless the context otherwise requires:

(5) ~~"Vendor"~~ "PROVIDER" shall have the same meaning as set forth in section ~~26-4-103 (21)~~ 26-4-103 (13.5), C.R.S.

SECTION 27. 22-82-103 (3), Colorado Revised Statutes, 1988 Repl. Vol., as amended, is amended to read:

22-82-103. Public school medical assistance pilot program - rules and regulations - report. (3) Districts chosen to participate in the pilot program shall be deemed to be ~~vendors~~ PROVIDERS under the "Colorado Medical Assistance Act". Each participating district shall be authorized to submit medicaid reimbursement requests for eligible medicaid services provided to students attending school in the district.

SECTION 28. 24-1.7-107 (3) (a) (II) (D), Colorado Revised Statutes, 1988 Repl. Vol., as amended, is amended to read:

24-1.7-107. Benchmarks for restructuring - savings. (3) On or before July 30, 1996, the departments of human services and health care policy and financing shall provide evidence to the joint budget committee and the general assembly that the departments will accomplish in fiscal year 1996-97 an additional total reduction of two million five hundred thousand dollars from their fiscal year 1994-95 budgets as

a result of restructuring, representing a total reduction over two years of five million dollars. As an ongoing update of the progress made toward this goal, the departments shall complete the following:

(a) On or before January 1, 1996, the department of human services shall provide a report to the general assembly specifically setting forth the progress of the department and recommending legislation for implementation as necessary in each of the following areas:

(II) Further coordinating and simplifying of programs and services, including, but not limited to, the following:

(D) Modifying procedures to increase recoveries of inappropriate payment to recipients or ~~vendors~~ PROVIDERS;

SECTION 29. 25-21-104, Colorado Revised Statutes, 1989 Repl. Vol., is amended to read:

25-21-104. Dental program - provider payments - eligibility. (1) The department shall administer a program of dental assistance to provide dentures, denture maintenance, and related dental services through ~~vendor~~ PROVIDER payments for persons receiving old age pension public assistance as defined in section 26-2-111 (2), C.R.S., and persons in nursing homes as old age pension recipients. The department shall promulgate necessary rules and regulations for the implementation of such program.

(2) The department shall administer the program through the issuance of ~~vendor~~ PROVIDER payments to dentists licensed under the provisions of article 35 of title 12, C.R.S., and shall establish a central registry of dentists participating in the program. The department shall also make a payment of not less than twelve dollars for each claim processed to an agency or agencies designated by the dental committee in each area.

(3) Any licensed dentist who participates in the program established in this article by providing services or appliances to any person presenting the appropriate certification obtained under section 25-21-105 (4) is eligible for ~~vendor~~ PROVIDER payments as stated in section 25-21-105 (5).

SECTION 30. 25-21-105 (3), Colorado Revised Statutes, 1989 Repl. Vol., is amended to read:

25-21-105. Copayment schedule - committee - eligibility - maximum payments. (3) The committee's duties shall be established by the department by rule and shall include among other duties: Designating an agency to administer the program for an area after consultation with the department and appropriate units of local government; accepting and approving applications; providing referrals to dentists; following up on ~~vendor~~ PROVIDER payments; and establishing a list of public and private dental resources in the county.

SECTION 31. 25-21-106 (1), Colorado Revised Statutes, 1989 Repl. Vol., is amended to read:

25-21-106. Operation period of program - review. (1) Claims by dentists for ~~vendor~~ PROVIDER payments under this article will be accepted for dental services rendered after October 1, 1977. Claims may not be accepted by the department for services rendered before October 1, 1977.

SECTION 32. 25.5-1-303 (3) (e), (3) (f), and (3) (g), Colorado Revised Statutes, 1989 Repl. Vol., as amended, are amended to read:

25.5-1-303. Powers and duties of the board - scope of authority - rules. (3) The board shall adopt rules in connection with the programs set forth in subsection (1) of this section governing the following:

(e) The establishment of a procedure to resolve disputes ~~which~~ THAT may arise between clients and the department or clients and ~~vendors~~ PROVIDERS;

(f) The requirements, obligations, and rights of ~~vendors and~~ providers, including policies and procedures related to ~~vendor~~ PROVIDER payments ~~which~~ THAT may affect client benefits;

(g) The establishment of a procedure to resolve disputes ~~which~~ THAT may arise between ~~vendors~~ PROVIDERS and between the department and ~~vendors~~ PROVIDERS.

SECTION 33. 26-1-106 (2), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

26-1-106. Final agency action - administrative law judge - authority of executive director - direction to seek waiver of single state agency requirement. (2) Hearings initiated by a licensed or certified provider ~~or vendor~~ of services shall be conducted by an administrative law judge for the state department and shall be considered final agency action and subject to judicial review in accordance with the provisions of section 24-4-106, C.R.S., for any party, including the state department, which shall be considered a person for such purposes.

SECTION 34. The introductory portion to 26-4-301.3 (2) (a), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

26-4-301.3. Managed care programs - guaranteed minimum enrollment for recipients who become ineligible for benefits - optional program. (2) As used in this section, unless the context otherwise requires:

(a) "Managed care program" means a health care service program provided pursuant to a risk contract by a ~~vendor~~ PROVIDER that is either a:

SECTION 35. The introductory portion to 26-4-403.7 (1) and 26-4-403.7 (3) (d), Colorado Revised Statutes, 1989 Repl. Vol., as amended, are amended to read:

26-4-403.7. Automated medical assistance administration. (1) The general assembly hereby finds and declares that the agency responsible for the administration of the state's medical assistance program would be more effective in its ability to streamline administrative functions of program administrators and ~~vendors~~ PROVIDERS under the program through the implementation of an automated system

that will provide for the following:

(3) The executive director of the state department shall develop and implement an automated system through which medical assistance claims and payments and eligibility determinations or other related transactions may be processed. The system shall provide for the use of automated electronic technologies. The automated system may be implemented in phases if deemed necessary by the executive director. The automated system shall be implemented only after the executive director determines that:

(d) Adequate ~~vendor~~ PROVIDER training has been provided for an orderly implementation.

SECTION 36. 26-4-404 (1), (2), and (3), Colorado Revised Statutes, 1989 Repl. Vol., as amended, are amended to read:

26-4-404. Providers - payments - rules. (1) (a) The state department shall establish rules and regulations for the payment of ~~vendors~~ PROVIDERS under this article. Within the limits of available funds, such rules and regulations shall provide reasonable compensation to such ~~vendors~~ PROVIDERS, but no ~~vendor~~ PROVIDER shall, by this section or any other provision of this article, be deemed to have any vested right to act as a ~~vendor~~ PROVIDER under this article or to receive any payment in addition to or different from that which is currently payable on behalf of a recipient at the time the medical benefits are provided by said ~~vendor~~ PROVIDER.

(b) (I) (A) On and after July 1, 1992, the state department rules and regulations established for the payment of ~~vendors~~ PROVIDERS under this article shall provide that services ~~which~~ THAT are compensable under both Title XIX and Title XVIII of the social security act shall be paid at either the rate established under Title XIX or the rate established under Title XVIII, whichever is lower.

(B) If any provision of this subparagraph (I) is found to be in conflict with any federal law or regulation, such conflicting portion of this subparagraph (I) is declared to be inoperative to the extent of the conflict.

(II) The general assembly shall annually appropriate to the state department of health care policy and financing one-half of the amount ~~which~~ THAT would have been paid to ~~vendors~~ PROVIDERS if the services described in subparagraph (I) of this paragraph (b) were compensated under both Title XIX and Title XVIII of the social security act, which shall be applied to the costs and expenses of any primary care provider incentive program established as a part of any managed care system established pursuant to section 26-4-104 (2).

(2) As to all payments made pursuant to this article, the state department rules and regulations for the payment of ~~vendors~~ PROVIDERS may include provisions

~~which~~ THAT encourage the highest quality of medical benefits and the provision thereof at the least expense possible.

(3) (a) As used in this subsection (3), "capitated" means a method of payment by which a ~~vendor~~ PROVIDER directly delivers or arranges for delivery of medical care

benefits for a term established by contract with the state department based on a fixed rate of reimbursement per recipient.

(b) (I) In order to provide medical benefits under this article on a capitated basis and subject to the condition imposed in subparagraph (II) of this paragraph (b), the state department is authorized to solicit negotiated contracts with ~~vendors~~ PROVIDERS based upon the requirements of this subsection (3). The state department may contract with one or more ~~vendors~~ PROVIDERS concerning the same medical services in a single geographic area.

(II) The state department may award a contract to one or more ~~vendors~~ PROVIDERS pursuant to subparagraph (I) of this paragraph (b) when the executive director determines that such contract will reduce the costs of providing medical benefits under this article.

(III) The state department may define groups of recipients by geographic area or other categories and may require that all members of the defined group obtain medical services through one or more ~~vendor~~ PROVIDER contracts entered into pursuant to this subsection (3).

(IV) Repealed.

SECTION 37. 26-4-405, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

26-4-405. Providers - hospital reimbursement. On or after July 1, 1987, the state department shall pay all licensed or certified hospitals under this article, except those hospitals operated by the department of human services, pursuant to a system of prospective payment, generally based on the elements of the medicare system of diagnosis-related groups. While developing the system of prospective payment, the state department shall constitute an advisory committee, whose members shall include hospital providers and be appointed by the executive director. The system of prospective payment shall consider utilizing the system of children's diagnosis-related groups, as developed by the national association of children's hospitals, for pediatric hospitalization, unless the medical services board finds that such groups are statistically invalid. If the state department determines that the medicare system of diagnosis-related groups has been expanded or revised sufficiently to reasonably apply to additional categories of ~~vendors~~ PROVIDERS under this article or if the state department develops a diagnosis-related groups system for additional categories of ~~vendors~~ PROVIDERS, which system includes hospitals operated by the department of human services, then the state department shall begin payment to such categories of ~~vendors~~ PROVIDERS under this article pursuant to the system of prospective payment developed under this section. The state department shall develop and administer a system for assuring appropriate utilization and quality of care provided by those ~~vendors~~ PROVIDERS who are reimbursed pursuant to the system of prospective payment developed under this section. The state department shall promulgate rules and regulations to provide for the implementation of this section.

SECTION 38. 26-4-407 (1), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

26-4-407. Providers of pharmaceutical services. (1) Consistent with the provisions of section 26-4-404 (1), and consistent with subsections (2) and (3) of this section, and subject to available appropriations, no ~~vendor~~ PROVIDER of pharmaceutical services who meets the conditions imposed by this article and who complies with the terms and conditions established by the state department and contracting health maintenance organizations and prepaid health plans shall be excluded from contracting for the provision of pharmaceutical services to recipients authorized in this article.

SECTION 39. 26-4-409, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

26-4-409. Providers - community mental health center and clinics - reimbursement. For the purpose of reimbursing community mental health center and clinic ~~vendors~~ PROVIDERS, the state department shall establish a price schedule annually with the department of human services in order to reimburse each ~~vendor~~ PROVIDER for its actual or reasonable cost of services.

SECTION 40. 26-4-415, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

26-4-415. Short title. This section and sections 26-4-416 to 26-4-419 shall be known and may be cited as the ~~"Vendor~~ "PROVIDER Assessment Plan".

SECTION 41. 26-4-416, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

26-4-416. Provider assessment plan created - purpose - conditional repeal. (1) For the purpose of enhancing payments to ~~vendors~~ PROVIDERS under this article and for partially funding the state medical assistance program as specified in this section and sections 26-4-417 and 26-4-418, there is hereby established a ~~"vendor~~ "PROVIDER assessment plan" to be administered by the state department. Such plan shall include the imposition of ~~vendor~~ PROVIDER assessments as set forth in sections 26-4-417 and 26-4-418 and such other moneys as may be allocated for the plan by the general assembly, including a portion of moneys previously allocated for the state "Reform Act for the Provision of Health Care for the Medically Indigent", article 15 of this title, hereafter referred to as the medically indigent program. Assessments made pursuant to sections 26-4-417 and 26-4-418 shall be collected by the state department and shall be transmitted to the state treasurer, who shall credit the same to the general fund. All moneys generated under the ~~vendor~~ PROVIDER assessment plan shall be subject to annual appropriation by the general assembly and shall be used to obtain federal financial participation under Title XIX of the federal "Social Security Act", 42 U.S.C.

(2) Moneys available for enhanced payments to ~~vendors~~ PROVIDERS subject to the ~~vendor~~ PROVIDER assessment plan shall not be used for any new services or eligible populations under the "Colorado Medical Assistance Act". No enhanced payments to ~~vendors~~ PROVIDERS under the ~~vendor~~ PROVIDER assessment plan shall be deemed vested or otherwise obligated to be continued if federal financial participation is discontinued.

(3) (a) The implementation of sections 26-4-415 to 26-4-419 is conditioned on written approval of a state medicaid plan amendment by the federal health care financing administration and, if such written approval has not been made for any reason and not received by the state department on or before June 30, 1992, said sections are repealed. In addition, sections 26-4-415 to 26-4-419 shall remain in effect only for so long as federal financial participation is available for ~~vendor~~ PROVIDER assessments for the making of enhanced ~~vendor~~ PROVIDER payments and other funding specified in this section or sections 26-4-417 and 26-4-418. In the event, as specified in writing by the state attorney general to the governor, that federal law does not allow or is amended to disallow such assessments or federal funds or otherwise prevent the implementation of sections 26-4-415 to 26-4-419, said sections are repealed.

(b) In the event federal financial participation is not available as provided in paragraph (a) of this subsection (3), then any assessments made or credited to the ~~vendor~~ PROVIDER assessment fund for which federal funds are not available shall be returned to the remitting ~~vendor~~ PROVIDER. Any overpayment to a ~~vendor~~ PROVIDER by the state department as a result of the denial of federal financial participation shall be recoverable by the state in the same manner and following the same procedures as specified in section 26-4-403 (2).

(4) The separate statutory provisions of the ~~vendor~~ PROVIDER assessment plan pertaining to hospitals and nursing facilities are declared severable from each other, but unified, dependent, and non-severable within the respective provisions of the plan.

(5) Nothing in sections 26-4-416 to 26-4-418 shall be deemed to affect or in any way limit the tax-exempt or nonprofit status of any ~~vendor~~ PROVIDER or entity subject to assessment under said sections.

(6) The department of health care policy and financing shall maintain records and compile an annual report on individual assessments, reallocated moneys, and corresponding federal funds generated under the ~~vendor~~ PROVIDER assessment plan and shall also maintain records of individual ~~vendor~~ PROVIDER payments and other uses of moneys therefrom.

SECTION 42. 26-4-417 (2) (a), the introductory portion to 26-4-417 (3), and 26-4-417 (4), Colorado Revised Statutes, 1989 Repl. Vol., as amended, are amended to read:

26-4-417. Hospital assessment - disproportionate share payments. (2) (a) Moneys generated from hospital assessments, moneys otherwise appropriated by the general assembly for the ~~vendor~~ PROVIDER assessment plan, and moneys from corresponding federal financial participation shall be used to make additional disproportionate share inpatient payment adjustments in addition to all other payments under the state medical assistance act. The percentage of payment adjustments shall be calculated by the state department based on the ratio of each hospital's portion of inpatient services rendered to low-income patients to its total inpatient services. The calculation shall be made by the state department based on the amount of actual payments made for medically indigent care pursuant to article 15 of this title and all other uncompensated care, excluding discounts for contractual allowances made to third-party payers.

(3) Moneys ~~which~~ THAT are not used for disproportionate share payments in accordance with subsection (2) of this section shall be used to pay the cost of the administration of the ~~vendor~~ PROVIDER assessment plan and to assist in funding only the following services and associated costs:

(4) Assessments and payments made pursuant to the ~~vendor~~ PROVIDER assessment plan shall be made in the same calendar quarter.

SECTION 43. 26-4-418 (2) (b), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

26-4-418. Nursing facility assessment - use of funds. (2) Assessments on nursing facilities shall be made in the following manner:

(b) The assessment shall be payable by nursing facilities yearly and collected by the state department during each state fiscal year on a monthly basis in twelve equal parts. Failure of a nursing facility to timely pay the assessment shall cause the state department to withhold the amount of the assessment from that ~~vendor's~~ PROVIDER'S reimbursement payment as an amount due and owing to the state.

SECTION 44. 26-4-504 (6), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

26-4-504. Personal needs benefits - amount - patient personal needs trust fund required - funeral and burial expenses - penalty for illegal retention and use - repeal. (6) Any overpayment of personal needs funds to a nursing facility or an intermediate care facility for the mentally retarded by the state department due to the omission, error, fraud, or defalcation of the nursing facility or intermediate care facility for the mentally retarded or any shortage in an audited patient personal needs trust fund shall be recoverable by the state on behalf of the recipient in the same manner and following the same procedures as specified in section 26-4-403 (2) for an overpayment to a ~~vendor~~ PROVIDER.

SECTION 45. 26-4-512 (3) (a), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

26-4-512. No public funds for abortion - exception. (3) (a) Except as provided in paragraph (b) of this subsection (3), any necessary medical services performed pursuant to this section shall be performed only in a licensed health care facility by a ~~vendor~~ PROVIDER who is a licensed physician.

SECTION 46. 26-4-608, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

26-4-608. Special provisions - post-eligibility treatment of income. Persons who receive services under this subpart 1 shall pay to the state department, or designated agent or ~~vendor~~ PROVIDER, all income remaining after application of federally allowed maintenance and medical deductions or shall pay the cost of home and community-based services rendered, whichever is less.

SECTION 47. 26-4-644 (2), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

26-4-644. Program established - financial eligibility. (2) Any person who accepts and receives services authorized under this subpart 3 shall pay to the state department, or to an agent or ~~vendor~~ PROVIDER designated by the state department, an amount ~~which~~ THAT shall be the lesser of the person's gross income, minus federally allowed maintenance and medical deductions, or the projected cost of services to be rendered to the person under the case plan. Such amount shall be reviewed and revised as necessary each time the case plan is reviewed.

SECTION 48. 26-4-684 (3) (b), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

26-4-684. Implementation of home and community-based services program for persons with brain injury authorized - federal waiver - duties of the department. (3) (b) A member of an eligible person's family, other than the person's spouse or a parent of a minor, may be employed to provide personal care services to such person. The maximum reimbursement for the services provided by a member of the person's family per year for an eligible person shall not exceed five thousand dollars per family per year. Standards that apply to other ~~vendors~~ PROVIDERS who provide personal care services apply to a family member who provides these services. In addition, a registered nurse shall supervise a family member in providing services to the extent indicated in the eligible person's plan of care.

SECTION 49. 26-4-703 (1) (d) (I) (J), (1) (e), and (7) (a), Colorado Revised Statutes, 1989 Repl. Vol., as amended, are amended to read:

26-4-703. Cost-containment and utilization control plan. (1) The state department, upon a determination of feasibility and the projected cost-savings by the executive director of said department, is hereby authorized to develop written implementation plans for the following cost-containment and utilization control measures:

(d) (I) Competitive procurement and contracting for health care services. However, factors concerning the selection of entities and methods to deliver health care pursuant to this article shall be assessed and such assessment shall be specifically addressed in the state's implementation plans. The factors to be assessed shall include, but are not limited to, all of the following:

(J) The feasibility of allowing any ~~vendor~~ PROVIDER that can meet the rate and service standards established in the bidding process to contract and deliver health care services.

(e) The requirement that reimbursement claims by ~~vendors~~ PROVIDERS be received by the fiscal agent for the state department within one hundred twenty days after the date on which any in-patient hospital, home health, hospice, or home and community-based services, including services for the elderly, blind, and disabled, services for the developmentally disabled, and services for persons living with AIDS, are rendered or after the medicare processing date for any medicare crossover claim and within one hundred twenty days after the date of service for any other health care

service. Such measure shall provide for the denial of payment for any late submittal, unless such submittal was beyond the ~~vendor's~~ PROVIDER'S control. The provision in this paragraph (e) shall be implemented only upon a determination by the executive director that adequate mechanisms are in place to assure that claims are not found to be out of timely filing due to delays in eligibility determination beyond the control of health care providers.

(7) (a) For services described in subparagraphs (I) to (III) of paragraph (b) of this subsection (7), the department shall release a formal request for information, developed with reasonable criteria and standards, for the provision of comprehensive services in order to provide the opportunity for affected medical assistance recipients and ~~vendors~~ PROVIDERS to provide input and make recommendations to the department with respect to the factors described in sub-subparagraphs (A) to (J) of subparagraph (I) of paragraph (d) of subsection (1) of this section during the request for information process. The department shall consult with the medical advisory council created in section 26-4-108 and with the medical assistance reform advisory committee created in section 26-4-704 during the request for information process. Nothing in this subsection (7) shall be construed to preclude the executive director of the department from establishing ad hoc advisory committees to obtain input and recommendations during the request for information process.

SECTION 50. 26-4-704 (1) (b), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

26-4-704. Medical assistance reform advisory committee. (1) In order for the agency responsible for developing an alternative plan for a nontraditional medical assistance program for the state, in accordance with section 26-4-702, to obtain sufficient input in developing such plan, there is hereby established a medical assistance reform advisory committee. The membership of the committee shall consist of fourteen members who shall be selected as follows:

(b) The speaker of the house of representatives and the president of the senate shall jointly appoint three members, each of whom shall respectively represent ~~vendors~~ PROVIDERS who participate in the medical assistance program, consumers under the medical assistance program or consumer advocates therefor, and members of the general public;

SECTION 51. Appropriation - appropriations in long bill to be adjusted. (1) In addition to any other appropriation, there is hereby appropriated, to the department of health care policy and financing, for the fiscal year beginning July 1, 1995, the sum of two hundred six thousand nine hundred two dollars ($206,902) and 0.5 FTE, or so much thereof as may be necessary, for the implementation of this act. Of this amount, ninety-eight thousand six hundred ninety-five dollars ($98,695) shall be from the general fund, and one hundred eight thousand two hundred seven dollars ($108,207) shall be from federal funds.

(2) For the implementation of this act, appropriations made in the annual general appropriation act to the department of health care policy and financing for the fiscal year beginning July 1, 1995, shall be adjusted as follows: The appropriation for the

department of health care policy and financing, medical programs division, medical services, is decreased by twenty-one thousand four hundred ninety-eight dollars ($21,498). Of said sum, ten thousand two hundred one dollars ($10,201) is from the general fund and eleven thousand two hundred ninety-seven dollars ($11,297) is from federal funds.

(3) In addition to any other appropriation, there is hereby appropriated, to the department of regulatory agencies, for allocation to the division of insurance, for the fiscal year beginning July 1, 1995, the sum of forty-three thousand six hundred sixty-nine dollars ($43,669) or so much thereof as may be necessary, for the implementation of this act. This amount shall be from exempt cash funds from private donations received by the department of regulatory agencies.

SECTION 52. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Approved: May 25, 1995