CHAPTER 169

HEALTH CARE POLICY AND FINANCING

HOUSE BILL 01-1343

BY REPRESENTATIVE(S) Clapp, Stafford, Fritz, Mace, Rhodes, Sanchez, Tapia, Williams S., and Young;
also SENATOR(S) Hernandez, Hanna, and Tupa.

AN ACT

CONCERNING THE ENROLLMENT OF MEDICAID RECIPIENTS IN MANAGED CARE, AND MAKING AN APPROPRIATION IN CONNECTION THEREWITH.

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

SECTION 1. 26-4-117 (1) (a), Colorado Revised Statutes, is amended to read:

26-4-117. Required features of managed care system. (1) **General features.** All medicaid managed care programs shall contain the following general features, in addition to others that the state department and the medical services board consider necessary for the effective and cost-efficient operation of those programs:

(a) **Recipient selection of MCO's.** (I) The general assembly finds that the ability of recipients to choose among competing health plans or health delivery systems is an important tool in encouraging such plans and delivery systems to compete for enrollees on the basis of quality and access. The state department shall, to the extent it determines feasible, provide medicaid-eligible recipients a choice among competing MCO's and a choice among providers within an MCO. Consistent with federal requirements and rules promulgated by the medical services board, the state department is authorized to assign a medicaid recipient to a particular MCO or primary care physician if:

(A) No other MCO or primary care physician has the capacity or expertise necessary to serve the recipient; or

(B) A recipient does not respond within twenty days after the date of a second notification of a request for selection of an MCO or primary care physician sent not less than forty-five days after delivery of a first notification.

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

(II) Consumers shall be informed of the choices available in their area by appropriate sources of information and counseling. This shall include an independent, objective facilitator acting under the supervision of the state department. The state department shall contract for the facilitator through a competitive bidding process. This function shall ensure that consumers have informed choice among available options to assure the fullest possible voluntary participation in managed care. The facilitator shall attempt to collect and consider, at a minimum, a consumer's usual and historic sources of care, linguistic needs, special medical needs, and transportation needs. The facilitator shall, if the enrollee requests, act as the enrollee's representative in resolving complaints and grievances with the MCO. The department, in conjunction with the medical services board, shall adopt regulations setting forth minimum disclosure requirements for all MCO's. Once a recipient is enrolled in an MCO, the recipient may not change to a different MCO for a period of ~~six~~ TWELVE months; except THAT THE RECIPIENT MAY DISENROLL WITHOUT GOOD CAUSE DURING THE FIRST NINETY DAYS OF ENROLLMENT OR ANY TIME THEREAFTER for good cause as determined by the state department. Good cause shall include but need not be limited to administrative error and an MCO's inability to provide its covered services to a recipient after reasonable efforts on the part of the MCO and the recipient, as defined by the medical services board. Based upon its assessment of any special needs of recipients with cognitive disabilities, the medical services board may adopt rules relating to any necessary good cause provisions for recipients with cognitive disabilities who are assigned to a particular MCO pursuant to subparagraph (I) of this paragraph (a).

(III) When eligible consumers choose to change or disenroll from their selected MCO, the state department shall monitor and gather data about the reasons for disenrolling, including denial of enrollment or disenrollment due to an act or omission of an MCO. The state department shall analyze this data and provide feedback to the plans or providers and shall use the information in the state department's contracting and quality assurance efforts. Persons who have been denied enrollment or have disenrolled due to an act or omission of an MCO may seek review by an independent hearing officer, as provided for and required under federal law and any state statute or regulation.

SECTION 2. Repeal. 26-4-301.3, Colorado Revised Statutes, is repealed as follows:

26-4-301.3. Managed care programs - guaranteed minimum enrollment for recipients who become ineligible for benefits - optional program. ~~(1) Beginning January 1, 1995, any recipient who becomes ineligible to receive benefits under this article shall continue to be eligible for enrollment in such program for the minimum enrollment period if the recipient:~~

~~(a) Has selected or been assigned to a federally qualified health maintenance organization or prepaid health plan within ninety days of becoming eligible for medicaid; and~~

~~(b) Has been enrolled in the managed care program for less than six months.~~

~~(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 provider that is either a:~~

~~(I) Health maintenance organization qualified pursuant to section 1301 (d) of the federal "Public Health Service Act"; or~~

~~(II) Prepaid health plan qualified as a community or migrant health center pursuant to section 1903 (m) of Title XIX of the federal "Social Security Act".~~

~~(b) "Minimum enrollment period" means the period beginning on the first day a recipient is initially enrolled in a managed care program under this article and ending six calendar months after such date.~~

~~(c) "Risk contract" means a contract which includes the possibility that loss may be incurred because the cost of providing services may exceed the payments made for services covered under the contract.~~

SECTION 3. 26-4-403 (11), Colorado Revised Statutes, is amended to read:

26-4-403. Recoveries - overpayments - penalties - interest - adjustments - liens. (11) (a) An entity that ~~administers a~~ PROVIDES managed care, ~~plan qualified pursuant to section 26-4-301.3~~ AS DEFINED IN SECTION 26-4-114, 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~~ PROVIDES 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 4. Appropriation - adjustments to the 2001 long bill. (1) In addition to any other appropriation, there is hereby appropriated, out of any moneys in the general fund not otherwise appropriated, to the department of health care policy and financing, medical programs administration, for payment of medicaid management information systems changes, for the fiscal year beginning July 1, 2001, the sum of six thousand two hundred dollars ($6,200), or so much thereof as may be necessary, for the implementation of this act. Said sum shall be subject to the "(M)" notation as defined in the general appropriation act. In addition, the general assembly anticipates that, for the fiscal year beginning July 1, 2001, the department of health care policy and financing, medical programs administration, will receive the sum of

eighteen thousand six hundred dollars ($18,600) in federal funds for the implementation of this act. Although these funds are not appropriated in this act, they are noted for the purpose of indicating the assumptions used relative to these funds.

(2) For the implementation of this act, appropriations made in the annual general appropriation act for the fiscal year beginning July 1, 2001, shall be adjusted as follows:

(a) The general fund appropriation to the department of health care policy and financing, medical services premiums, is decreased by three hundred thousand dollars ($300,000).

(b) The federal funds anticipated to be received by the department of health care policy and financing, medical services premiums, are reduced by three hundred thousand dollars ($300,000).

SECTION 5. Effective date. This act shall take effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly that is allowed for submitting a referendum petition pursuant to article V, section 1 (3) of the state constitution; except that, if a referendum petition is filed against this act or an item, section, or part of this act within such period, then the act, item, section, or part, if approved by the people, shall take effect on the date of the official declaration of the vote thereon by proclamation of the governor.

Approved: May 22, 2001