CHAPTER 319

HEALTH CARE POLICY AND FINANCING

HOUSE BILL 07-1346

BY REPRESENTATIVE(S) Buescher, Pommer, White, Frangas, Labuda, Massey, McGihon, and Riesberg;
also SENATOR(S) Tapia, Keller, Johnson, Boyd, and Sandoval.

AN ACT

CONCERNING MANAGED CARE IN THE MEDICAL ASSISTANCE PROGRAM, AND MAKING AN APPROPRIATION THEREFOR.

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

SECTION 1. Part 4 of article 5 of title 25.5, Colorado Revised Statutes, is amended BY THE ADDITION OF THE FOLLOWING NEW SECTIONS to read:

25.5-5-407.5. Prepaid inpatient health plan agreements - rules. (1) SUBJECT TO THE RECEIPT OF ANY REQUIRED FEDERAL AUTHORIZATIONS, PURSUANT TO THE REQUIREMENTS OF THIS SECTION, THE STATE DEPARTMENT MAY ENTER INTO PREPAID INPATIENT HEALTH PLAN AGREEMENTS, REFERRED TO IN THIS SECTION AS A "PIHP AGREEMENT", WITH AN ENTITY THAT:

(a) PROVIDES MEDICAL SERVICES TO ENROLLEES ON THE BASIS OF PREPAID CAPITATION PAYMENTS, OR OTHER PAYMENT ARRANGEMENTS THAT DO NOT USE PAYMENT RATES CONTAINED IN THE STATE PLAN; AND

(b) PROVIDES, ARRANGES FOR, OR OTHERWISE HAS RESPONSIBILITY FOR THE PROVISION OF ANY INPATIENT HOSPITAL OR INSTITUTIONAL SERVICES FOR ITS ENROLLEES.

(2) (a) A PIHP AGREEMENT MAY INCLUDE A PROVISION FOR A QUALITY INCENTIVE PAYMENT THAT IS DISTRIBUTED TO THE CONTRACTOR WITHIN SIX MONTHS FOLLOWING THE END OF EACH FISCAL YEAR IF THE CONTRACTOR SUBSTANTIALLY EXCEEDS PREDETERMINED QUALITY INDICATORS. THE QUALITY INDICATORS SHALL BE BASED UPON BROADLY ACCEPTED MEASURES OF PERFORMANCE ADOPTED BY RULE OF THE STATE BOARD AND AGREED UPON AT THE OUTSET OF THE CONTRACT PERIOD, AND SHALL INCLUDE, BUT NEED NOT BE LIMITED TO, THE HEALTH PLAN

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

EMPLOYERS DATA AND INFORMATION SET MEASURES. THE QUALITY INCENTIVE PAYMENT MAY BE MADE PROPORTIONAL IF THE STATE BOARD ESTABLISHES MULTIPLE QUALITY MEASUREMENTS. THE QUALITY INCENTIVE PAYMENTS SHALL NOT EXCEED THE TOTAL COST SAVINGS CREATED UNDER THE PIHP AGREEMENT, AS DETERMINED BY COMPARISON OF THE PIHP MEMBERS WITH AN ACTUARIALLY EQUIVALENT FEE-FOR-SERVICE POPULATION, AND THE QUALITY INCENTIVE PAYMENT SHALL NOT EXCEED FIVE PERCENT OF THE TOTAL MEDICAID PAYMENTS RECEIVED BY THE CONTRACTOR DURING THE PERFORMANCE PERIOD OF THE PIHP AGREEMENT.

(b) (I) EXCEPT AS PROVIDED FOR IN SUBPARAGRAPH (II) OF THIS PARAGRAPH (b), THE CONTRACTOR SHALL DISTRIBUTE AT LEAST SEVENTY-FIVE PERCENT OF THE INCENTIVE PAYMENT TO PROVIDERS WITH WHICH IT HAS CONTRACTED TO SERVE MEDICAID RECIPIENTS.

(II) SUBPARAGRAPH (I) OF THIS PARAGRAPH (b) SHALL NOT APPLY TO A CONTRACTOR THAT HAS AN EXCLUSIVE CONTRACT WITH A SINGLE MEDICAL GROUP IN A SPECIFIC GEOGRAPHIC AREA TO PROVIDE OR ARRANGE FOR HEALTH CARE SERVICES FOR ITS MEMBERS, SUCH AS A MULTI-SPECIALTY GROUP MODEL. SUCH A CONTRACTOR SHALL NEGOTIATE THE DISTRIBUTION OF THE QUALIFIED INCENTIVE PAYMENT WITH THE MEDICAL GROUP.

(3) SUBJECT TO THE APPROVAL OF THE STATE BOARD, A PIHP AGREEMENT MAY ALSO PROVIDE FOR AN INCREASE IN THE FEE PAID TO THE CONTRACTOR IN AN AMOUNT REASONABLY CALCULATED TO COVER THE COSTS OF COLLECTING AND MAINTAINING THE MEDICAL RECORDS OF RECIPIENTS THROUGH AN ELECTRONIC MEDICAL RECORDS SYSTEM.

(4) NOTHING IN THIS SECTION SHALL PREVENT, TO THE EXTENT POSSIBLE, A GOVERNMENT-OWNED ENTITY FROM USING CERTIFIED PUBLIC EXPENDITURE OR OTHER FEDERALLY-RECOGNIZED FINANCING MECHANISMS TO PROVIDE THE STATE SHARE FOR THE FEDERAL MATCH TO ENHANCE CAPITATION PAYMENTS UP TO OR ABOVE THE ONE HUNDRED PERCENT LIMIT CONTAINED IN SECTION 25.5-5-408 (9). THE STATE SHALL NOT BE OBLIGATED TO INCREASE ANY GENERAL FUND EXPENDITURES BECAUSE OF THE USE OF CERTIFIED PUBLIC EXPENDITURE OR OTHER FEDERALLY-RECOGNIZED FINANCING MECHANISM PURSUANT TO THIS SUBSECTION (4).

25.5-5-407.7. Disability care coordination organization - rules. SUBJECT TO THE RECEIPT OF ANY REQUIRED FEDERAL AUTHORIZATIONS, THE STATE DEPARTMENT MAY ENTER INTO AN AGREEMENT FOR THE PROVISION OF CARE TO RECIPIENTS WITH A DISABILITY WITH A DISABILITY CARE COORDINATION ORGANIZATION IDENTIFIED AS THE NONPROFIT ORGANIZATION IN SECTION 26-4-537.

SECTION 2. Part 1 of article 6 of title 25.5, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

25.5-6-112. Plan of financial operation - purpose - approval - financial audits - rules - repeal. (1) (a) FOR THE PURPOSES OF IMPLEMENTING SECTION 25.5-6-111, THE APPLICANTS FOR THE PILOT PROGRAM SHALL SUBMIT A PROPOSED PLAN OF FINANCIAL OPERATION TO THE INSURANCE COMMISSIONER, WHICH PLAN SHALL DESCRIBE THE FINANCIAL OPERATION AND SOLVENCY OF THE PROGRAM.

(b) THE PLAN OF FINANCIAL OPERATION SHALL BE DEVELOPED AFTER THE APPLICANT HAS GIVEN NOTICE TO THE PUBLIC THAT IT WILL ACCEPT WRITTEN COMMENTS CONCERNING THE CONTENTS OF THE PLAN FROM ANY INTERESTED PARTY. THE APPLICANT SHALL CONSIDER THE COMMENTS WHEN IT DEVELOPS THE PLAN. COPIES OF ANY WRITTEN COMMENTS RECEIVED BY THE APPLICANT SHALL BE TRANSMITTED TO THE INSURANCE COMMISSIONER ALONG WITH THE PLAN OF FINANCIAL OPERATION FOR THE PROGRAM.

(c) AT THE TIME THAT IT SUBMITS THE PROPOSED PLAN OF FINANCIAL OPERATION TO THE INSURANCE COMMISSIONER, THE APPLICANT SHALL PROVIDE A COPY OF THE PROPOSED PLAN OF FINANCIAL OPERATION TO ANY PARTY WHO HAS REQUESTED A COPY OF THE PLAN, TOGETHER WITH A NOTICE THAT WRITTEN COMMENTS ON THE PROPOSED PLAN MAY BE SUBMITTED TO THE INSURANCE COMMISSIONER WITHIN THIRTY DAYS.

(d) AS PART OF THE INSURANCE COMMISSIONER'S REVIEW OF THE PROPOSED PLAN OF FINANCIAL OPERATION, THE INSURANCE COMMISSIONER SHALL GIVE DUE CONSIDERATION TO THE WRITTEN COMMENTS SPECIFIED IN PARAGRAPHS (b) AND (c) OF THIS SUBSECTION (1). WITHIN SIXTY DAYS AFTER HIS OR HER RECEIPT OF THE PROPOSED PLAN, THE INSURANCE COMMISSIONER SHALL APPROVE THE PLAN OF FINANCIAL OPERATION IF THE INSURANCE COMMISSIONER DETERMINES THAT IT WILL ACCOMPLISH THE PURPOSE OF ENSURING THE FINANCIAL SOLVENCY OF THE PILOT PROGRAM IN SECTION 25.5-6-111.

(2) IF THE PLAN IS NOT APPROVED BY THE INSURANCE COMMISSIONER, THE INSURANCE COMMISSIONER SHALL RETURN THE PLAN TO THE APPLICANTS WITH COMMENTS OUTLINING THE REASONS FOR ITS REJECTION. THE APPLICANT SHALL HAVE THE ABILITY TO REORGANIZE AND RESUBMIT THE PLAN TO THE INSURANCE COMMISSIONER WITHIN A PERIOD OF TIME AGREED TO BY THE COMMISSIONER.

(3) (a) IF, AT ANY TIME AFTER APPROVAL OF THE INITIAL PLAN OF FINANCIAL OPERATION, THE APPLICANT DETERMINES THAT IT IS NECESSARY TO AMEND THE PLAN OF FINANCIAL OPERATION IN ORDER TO IMPLEMENT THE PURPOSES OF THIS SECTION, THE APPLICANT MAY AMEND AND MODIFY THE PLAN OF FINANCIAL OPERATION UTILIZING THE PROCEDURES SPECIFIED IN SUBSECTION (1) OF THIS SECTION.

(b) IF, AT ANY TIME AFTER APPROVAL OF THE INITIAL PLAN OF FINANCIAL OPERATION, THE INSURANCE COMMISSIONER DETERMINES THAT IT IS NECESSARY TO AMEND THE PLAN OF FINANCIAL OPERATION IN ORDER TO IMPLEMENT THE PURPOSES OF SECTION 25.5-6-111 AND THE APPLICANT FAILS TO ENACT SUCH AMENDMENT OR AMENDMENTS WITHIN A REASONABLE TIME AFTER NOTICE FROM THE INSURANCE COMMISSIONER THAT THE AMENDMENT OR AMENDMENTS ARE NECESSARY, THE INSURANCE COMMISSIONER SHALL PROMULGATE RULES NECESSARY TO AMEND THE PLAN SO THAT IT IMPLEMENTS THE PURPOSES OF THIS SECTION AFTER NOTICE AND PUBLIC HEARING AS PROVIDED IN SECTION 24-4-105, C.R.S.

(4) ANY RULES PROMULGATED BY THE INSURANCE COMMISSIONER PURSUANT TO SUBSECTION (3) OF THIS SECTION SHALL CONTINUE IN FULL FORCE AND EFFECT UNTIL MODIFIED BY THE INSURANCE COMMISSIONER AFTER NOTICE AND PUBLIC HEARING OR UNTIL SUPERSEDED BY A PLAN OF FINANCIAL OPERATION OR AMENDMENT

SUBMITTED BY THE APPLICANT AND APPROVED BY THE INSURANCE COMMISSIONER PURSUANT TO THE PROVISIONS OF THIS SECTION.

(5) NOT LATER THAN JULY 1, 2008, AND JULY 1 OF EACH SUCCEEDING YEAR, THE APPLICANT SHALL SUBMIT AN AUDITED FINANCIAL REPORT FOR THE PROGRAM ESTABLISHED IN SECTION 25.5-6-111 FOR THE PRECEDING CALENDAR YEAR TO THE COMMISSIONER IN A FORM PROVIDED OR PRESCRIBED BY THE INSURANCE COMMISSIONER.

(6) THE FINANCIAL STATUS OF THE PROGRAM SHALL BE SUBJECT TO EXAMINATION BY THE INSURANCE COMMISSIONER OR THE INSURANCE COMMISSIONER'S DESIGNEE. SUCH EXAMINATION SHALL BE CONDUCTED AT LEAST ONCE EVERY FIVE YEARS.

(7) IN THE EVENT OF ANY INSOLVENCY OR IMPAIRMENT OR DISSOLUTION OF THE PILOT PROGRAM BY THE GENERAL ASSEMBLY, THE COMMISSIONER SHALL HAVE THOSE RIGHTS AND DUTIES SPECIFIED IN PARTS 4 AND 5 OF ARTICLE 3 OF TITLE 10, C.R.S., TO ENSURE ABATEMENT OF ANY DELINQUENCY OR THE ORDERLY TERMINATION OF THE AFFAIRS AND OBLIGATIONS OF THE PROGRAM.

(8) THIS SECTION IS REPEALED, EFFECTIVE JULY 1 OF THE FIFTH YEAR FOLLOWING IMPLEMENTATION OF THE PILOT PROGRAM CREATED IN SECTION 25.5-6-111.

SECTION 3. 25.5-5-403 (1) (a), Colorado Revised Statutes, is amended to read:

25.5-5-403. Managed care organizations - definitions. (1) (a) **Managed care.** As used in this part 4, "managed care" means:

(I) The delivery by a managed care organization, as defined in subsection (2) of this section, of a predefined set of services to recipients; ~~or~~

(II) The delivery of services provided by the primary care physician program established in section 25.5-5-407; OR

(III) THE DELIVERY OF SERVICES PROVIDED BY A PREPAID INPATIENT HEALTH PLAN AGREEMENT, PURSUANT TO SECTION 25.5-5-407.5.

SECTION 4. 25.5-5-408 (1) (b) and (9), Colorado Revised Statutes, are amended, and the said 25.5-5-408 is further amended BY THE ADDITION OF A NEW SUBSECTION, to read:

25.5-5-408. Capitation payments - availability of base data - adjustments - rate calculation - capitation payment proposal - preference - assignment of medicaid recipients. (1) (b) ~~Except as otherwise provided in paragraph (d) of this subsection (1), under no circumstances, including competitive bidding as set forth in paragraph (c) of this subsection (1), shall the state department pay a capitation payment to an MCO that exceeds ninety-five percent of the direct health care cost of providing these same services on an actuarially equivalent Colorado medicaid population group consisting of unassigned recipients and recipients in the primary care physician program provided in section 25.5-5-407.~~ A certification by a qualified actuary retained by the state department shall be conclusive evidence that the state department has correctly calculated the direct health care cost of providing

these same services on an actuarially equivalent Colorado medicaid population group consisting of unassigned recipients and recipients in the primary care physician program provided in section 25.5-5-407.

(9) The rate-setting process referenced in subsection (6) of this section shall include a time period after the MCOs have received the direct health care cost of providing these same services on an actuarially equivalent Colorado medicaid population group consisting of unassigned recipients and recipients in the primary care physician program provided in section 25.5-5-407, for each MCO to submit to the state department the MCO's capitation payment proposal, which shall not exceed ~~ninety-five~~ ONE HUNDRED percent of the direct health care cost of providing these same services on an actuarially equivalent Colorado medicaid population group consisting of unassigned recipients and recipients in the primary care physician program provided in section 25.5-5-407. The state department shall provide to the MCOs the MCO's specific adjustments to be included in the calculation of the MCO's proposal. Each MCO's capitation payment proposal shall meet the requirements of section 25.5-5-404 (1) (k) and (1) (l).

(12) NOTHING IN THIS SECTION SHALL PREVENT, TO THE EXTENT POSSIBLE, AN MCO THAT IS ALSO A GOVERNMENT-OWNED ENTITY FROM USING CERTIFIED PUBLIC EXPENDITURE OR OTHER FEDERALLY-RECOGNIZED FINANCING MECHANISMS TO PROVIDE THE STATE SHARE FOR THE FEDERAL MATCH TO ENHANCE CAPITATION PAYMENTS UP TO OR ABOVE THE ONE HUNDRED PERCENT LIMIT CONTAINED IN SUBSECTION (9) OF THIS SECTION. THE STATE SHALL NOT BE OBLIGATED TO INCREASE ANY GENERAL FUND EXPENDITURES BECAUSE OF THE USE OF CERTIFIED PUBLIC EXPENDITURE OR OTHER FEDERALLY-RECOGNIZED FINANCING MECHANISM PURSUANT TO THIS SUBSECTION (12).

SECTION 5. 10-16-411, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

10-16-411. Protection against insolvency. (1.5) (a) (I) NOTWITHSTANDING ANY PROVISION OF SUBSECTION (2) OR (4) OF THIS SECTION TO THE CONTRARY, A HEALTH MAINTENANCE ORGANIZATION WHOSE SOLE BUSINESS IS PROVIDING HEALTH CARE SERVICES TO RECIPIENTS UNDER THE "COLORADO MEDICAL ASSISTANCE ACT", ARTICLES 4 TO 6 OF TITLE 25.5, C.R.S., THE CHILDREN'S BASIC HEALTH PLAN, ARTICLE 8 OF TITLE 25.5, C.R.S., OR MEDICARE UNDER TITLE XVIII OF THE FEDERAL "SOCIAL SECURITY ACT", AS AMENDED, SHALL MAINTAIN A MINIMUM SURPLUS OF NOT LESS THAN FOUR MILLION DOLLARS AND SHALL MAINTAIN A CLAIMS LIABILITY WITHIN ITS FINANCIAL STATEMENT EQUAL TO THE GREATER OF:

(A) ONE MONTH OF FEDERAL AND STATE REIMBURSEMENTS RECEIVED BY THE HEALTH MAINTENANCE ORGANIZATION FOR SERVICES PROVIDED TO HEALTH CARE RECIPIENTS; OR

(B) THE HEALTH MAINTENANCE ORGANIZATION'S TOTAL OUTSTANDING CLAIMS LIABILITIES.

(II) A HEALTH MAINTENANCE ORGANIZATION SUBJECT TO THIS PARAGRAPH (a) ANNUALLY SHALL SUBMIT AN OPINION BY A QUALIFIED ACTUARY THAT ATTESTS THAT THE HEALTH MAINTENANCE ORGANIZATION'S SURPLUS LEVEL AND

OUTSTANDING CLAIMS LIABILITY MEET THE REQUIREMENTS OF THIS PARAGRAPH (a).

SECTION 6. 25-36-101, Colorado Revised Statutes, as enacted by Senate Bill 07-097, enacted at the First Regular Session of the Sixty-sixth General Assembly, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

25-36-101. Short-term grants for innovative health programs - grant fund - creation - repeal. (8) (a) FOR THE 2007-08 FISCAL YEAR, OF THE MONEYS TRANSFERRED PURSUANT TO SECTIONS 24-22-115 (1) (b) AND 24-75-1104.5 (1.5) (a) (IX) AND (1.5) (b), C.R.S., THE LESSER OF THIRTY-SEVEN THOUSAND FIVE HUNDRED DOLLARS OR THREE AND EIGHT TENTHS PERCENT OF THE AMOUNT ALLOCATED TO THE SHORT-TERM INNOVATIVE HEALTH PROGRAM GRANT FUND SHALL BE APPROPRIATED TO THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FOR STUDYING THE USE OF PREPAID INPATIENT HEALTH PLAN AGREEMENTS PURSUANT TO SECTION 25.5-5-407.5, C.R.S.

(b) THIS SUBSECTION (3) IS REPEALED, EFFECTIVE JULY 1, 2008.

SECTION 7. Appropriation. In addition to any other appropriation, there is hereby appropriated, to the department of health care policy and financing, for allocation to the executive director's office, for the fiscal year beginning July 1, 2007, the sum of seventy-five thousand dollars ($75,000), or so much thereof as may be necessary, for the implementation of this act. Of said sum, thirty-seven thousand five hundred dollars ($37,500) shall be from the short-term innovative health program grant fund created in section 25-36-101 (2), Colorado Revised Statutes, and thirty-seven thousand five hundred dollars ($37,500) shall be from federal funds.

SECTION 8. Section 14 (5) (c) of Senate Bill 07-097, enacted at the First Regular Session of the Sixty-sixth General Assembly, is amended to read:

Section 14. **Appropriation** (5) (c) In addition to any other appropriation, there is hereby appropriated, out of any moneys in the short-term innovative health program grant fund created in section 25-36-101 (2), Colorado Revised Statutes, not otherwise appropriated, to the department of public health and environment, for the fiscal year beginning July 1, 2007, the sum of ~~one million four hundred thousand dollars ($1,400,000)~~, ONE MILLION THREE HUNDRED SIXTY-TWO THOUSAND FIVE HUNDRED DOLLARS ($1,362,500), cash funds exempt, and 1.0 FTE, or so much thereof as may be necessary, for the implementation of this act.

SECTION 9. 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 29, 2007