CHAPTER 129

HEALTH CARE POLICY AND FINANCING

SENATE BILL 08-148

BY SENATOR(S) Penry;
also REPRESENTATIVE(S) Kefalas, Borodkin, Labuda, McGihon, and Todd.

AN ACT

CONCERNING THE MODIFICATION OF DEFINITIONS FOR THE STATEWIDE MANAGED CARE SYSTEM UNDER THE "COLORADO MEDICAL ASSISTANCE ACT".

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

SECTION 1. 25.5-5-402 (3) and (5), Colorado Revised Statutes, are amended to read:

25.5-5-402. Statewide managed care system. (3) **Bidding.** The state department is authorized to institute a program for competitive bidding pursuant to section 24-103-202 or 24-103-203, C.R.S., for managed care ~~organizations~~ ENTITIES seeking to provide medical services for medicaid clients eligible to be enrolled in managed care. The state department is authorized to award contracts to more than one offeror. The state department procedures shall seek to use competitive bidding procedures to maximize the number of managed care choices available to medicaid clients over the long term that meet the requirements of sections 25.5-5-404 and 25.5-5-406.

(5) **Graduate medical education.** The state department shall continue the graduate medical education, referred to in this subsection (5) as "GME", funding to teaching hospitals that have graduate medical education expenses in their medicare cost report and are participating as providers under one or more ~~MCO~~ MCE with a contract with the state department under this part 4. GME funding for recipients enrolled in an ~~MCO~~ MCE shall be excluded from the premiums paid to the ~~MCO~~ MCE and shall be paid directly to the teaching hospital. The state board shall adopt rules to implement this subsection (5) and establish the rate and method of reimbursement.

SECTION 2. 25.5-5-403, Colorado Revised Statutes, is amended to read:

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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.

25.5-5-403. Definitions. AS USED IN THIS PART 4, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(1) "BEHAVIORAL HEALTH ORGANIZATION", REFERRED TO IN THIS PART 4 AS A "BHO", MEANS AN ENTITY CONTRACTING WITH THE STATE DEPARTMENT TO PROVIDE ONLY BEHAVIORAL HEALTH SERVICES.

(2) "ESSENTIAL COMMUNITY PROVIDER", REFERRED TO IN THIS PART 4 AS AN "ECP", MEANS A HEALTH CARE PROVIDER THAT:

(a) HAS HISTORICALLY SERVED MEDICALLY NEEDY OR MEDICALLY INDIGENT PATIENTS AND THAT DEMONSTRATES A COMMITMENT TO SERVE LOW-INCOME AND MEDICALLY INDIGENT POPULATIONS WHO COMPRISE A SIGNIFICANT PORTION OF ITS PATIENT POPULATION OR, IN THE CASE OF A SOLE COMMUNITY PROVIDER, SERVES THE MEDICALLY INDIGENT PATIENTS WITHIN ITS MEDICAL CAPABILITY; AND

(b) WAIVES CHARGES OR CHARGES FOR SERVICES ON A SLIDING SCALE BASED ON INCOME AND DOES NOT RESTRICT ACCESS OR SERVICES BECAUSE OF A CLIENT'S FINANCIAL LIMITATIONS.

~~(1) (a) **Managed care.** As used in this part 4,~~ (3) (a) "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 DELIVERED BY A MANAGED CARE ENTITY AS DEFINED IN SUBSECTION (4) OF THIS SECTION; OR

(II) The delivery of services provided by the primary care physician program established in section 25.5-5-407, WHICH IS A PRIMARY CARE CASE MANAGER AS DEFINED IN SUBSECTION (8) OF THIS SECTION. ~~or~~

(III) ~~The delivery of services provided by a prepaid inpatient health plan agreement, pursuant to section 25.5-5-407.5.~~

(b) Nothing in this section shall be deemed to affect the benefits authorized for recipients of the state medical assistance program.

(4) "MANAGED CARE ENTITY", REFERRED TO IN THIS PART 4 AS AN "MCE", MEANS AN ENTITY THAT ENTERS INTO A CONTRACT TO PROVIDE SERVICES IN A MANAGED CARE SYSTEM, INCLUDING MANAGED CARE ORGANIZATIONS, PREPAID INPATIENT HEALTH PLANS, AND PREPAID AMBULATORY HEALTH PLANS BUT EXCLUDING PRIMARY CARE CASE MANAGERS, AS DEFINED IN SUBSECTION (8) OF THIS SECTION.

~~(2) **Managed care organization.** As used in this part 4,~~ (5) "Managed care organization", referred to in this part 4 as an "MCO", means an entity contracting with the state department that ~~provides, delivers, arranges for, pays for, or reimburses any of the costs of health care services through the recipient's use of health care providers managed by, owned by, under contract with, or employed by the entity because the entity or the state department either requires the recipient's use of those providers or creates incentives, including financial incentives, for the recipient's use of those providers~~ MEETS THE DEFINITION OF MANAGED CARE

ORGANIZATION AS DEFINED IN 42 CFR 438.2.

~~(3) **Essential community provider.** "Essential community provider" or "ECP" means a health care provider that:~~

~~(a) Has historically served medically needy or medically indigent patients and demonstrates a commitment to serve low-income and medically indigent populations who make up a significant portion of its patient population or, in the case of a sole community provider, serves the medically indigent patients within its medical capability; and~~

~~(b) Waives charges or charges for services on a sliding scale based on income and does not restrict access or services because of a client's financial limitations.~~

(6) "PREPAID AMBULATORY HEALTH PLAN", REFERRED TO IN THIS PART 4 AS A "PAHP", MEANS AN ENTITY CONTRACTING WITH THE STATE DEPARTMENT THAT MEETS THE DEFINITION OF PREPAID AMBULATORY HEALTH PLAN AS DEFINED IN 42 CFR 438.2.

(7) "PREPAID INPATIENT HEALTH PLAN", REFERRED TO IN THIS PART 4 AS "PIHP", MEANS AN ENTITY CONTRACTING WITH THE STATE DEPARTMENT THAT MEETS THE DEFINITION OF PREPAID INPATIENT HEALTH PLAN AS DEFINED IN 42 CFR 438.2.

(8) "PRIMARY CARE CASE MANAGER", REFERRED TO IN THIS PART 4 AS A "PCCM", MEANS AN ENTITY CONTRACTING WITH THE STATE DEPARTMENT THAT MEETS THE DEFINITION OF PRIMARY CARE CASE MANAGER AS DEFINED IN 42 CFR 438.2.

SECTION 3. 25.5-5-404, Colorado Revised Statutes, is amended to read:

25.5-5-404. Selection of managed care entities. (1) In addition to any other criteria specified in rule by the state board, in order to participate in the managed care system, the ~~MCO~~ MCE shall comply with specific criteria that include, but are not limited to, the following:

(a) The ~~MCO~~ MCE shall not interfere with appropriate medical care decisions rendered by the provider nor penalize the provider for requesting medical services outside the standard treatment protocols developed by the ~~MCO~~ MCE or its contractors.

(b) The ~~MCO~~ MCE shall make or ~~assure~~ ENSURE payments to providers within the time allowed for the state to make payments on state liabilities under the rules adopted by the department of personnel pursuant to section 24-30-202 (13), C.R.S.

(c) The ~~MCO~~ MCE shall have an educational component in its plan that takes into consideration recipient input and that informs recipients as to availability and use of the medical services system, appropriate preventive health care procedures, self-care, and appropriate health care utilization.

(d) The ~~MCO~~ MCE shall provide the minimum benefit requirements as established by the state board.

(e) The ~~MCO~~ MCE shall provide necessary and appropriate services to recipients that shall include but not be limited to the following:

(I) With respect to recipients who are unable to make decisions for themselves, the ~~MCO~~ MCE and all relevant providers in the ~~MCO's~~ MCE'S network serving the recipients shall collaborate with the designated advocate or family member in all decision-making, including enrollment and disenrollment.

(II) The ~~MCO~~ MCE shall deliver services that are covered benefits in a manner that accommodates or is compatible with the recipient's ability to fulfill duties and responsibilities in work and community activities.

(f) The ~~MCO~~ MCE shall provide appropriate use of ancillary health care providers by appropriate qualified health care professionals.

(g) The ~~MCO~~ MCE shall comply with all data collection and reporting requirements established by the state department.

(h) The ~~MCO~~ MCE shall, to the extent provided by law or waiver, provide recipient benefits that the state board shall develop and the state department shall implement in partnership with local government and the private sector, including but not limited to:

(I) Recipient options to rent, purchase, or own durable medical equipment; OR

(II) ~~Recognition for improved health status outcomes; or~~

(III) Receipt of medical disposable supplies without charge.

(i) The ~~MCO~~ MCE shall comply with utilization requirements established by the state department.

(j) The ~~MCO~~ MCE shall develop and utilize a form or process for measuring group and individual recipient health outcomes, including but not limited to the use of tools or methods that identify increased health status or maintenance of the individual's highest level of functioning, determine the degree of medical access, and reveal recipient satisfaction and habits. Such tools shall include the use of client surveys, anecdotal information, complaint and grievance data, and disenrollment information. The ~~MCO~~ MCE shall annually submit a care management report to the state department that describes techniques used by the ~~MCO~~ MCE to provide more efficient use of health care services, better health status for populations served, and better health outcomes for individuals.

(k) Except as provided ~~for~~ in paragraph (m) of this subsection (1), for capitation payments effective on and after July 1, 2003, ~~the MCO~~ AN MCE THAT IS CONTRACTING FOR A DEFINED SCOPE OF SERVICES UNDER A RISK CONTRACT shall certify the financial stability of the ~~MCO~~ MCE pursuant to criteria established by the division of insurance and shall certify, as a condition of entering into a contract with the state department, that the capitation payments set forth in the contract between the ~~MCO~~ MCE and the state department are sufficient to ~~assure~~ ENSURE the financial stability of the ~~MCO~~ MCE with respect to delivery of services to the

medicaid recipients covered in the contract.

(l) Except as provided ~~for~~ in paragraph (m) of this subsection (1), for capitation payments effective on and after July 1, 2003, ~~the MCO~~ AN MCE THAT IS CONTRACTING FOR A DEFINED SCOPE OF SERVICES UNDER A RISK CONTRACT shall certify, through a qualified actuary retained by the ~~MCO~~ MCE, that the capitation payments set forth in the contract between the ~~MCO~~ MCE and the state department comply with all applicable federal and state requirements that govern said capitation payments. For purposes of this paragraph (l), a "qualified actuary" means a person deemed as such by rule promulgated by the commissioner of insurance.

(m) An MCO providing services under the PACE program as described in section 25.5-5-412 shall certify that the capitation payments are in compliance with applicable federal and state requirements that govern said capitation payments and that the capitation payments are sufficient to ~~assure~~ ENSURE the financial viability of the MCO with respect to the delivery of services to the PACE program participants covered in the contract.

(n) The ~~MCO~~ MCE shall ~~provide assurance~~ ENSURE, TO THE EXTENT THAT VOLUNTARY ENROLLMENT INTO THE MCE IS POSSIBLE, that the ~~MCO~~ MCE has not provided to a recipient any premiums or other inducements in exchange for the recipient selecting the ~~MCO~~ MCE for coverage.

(o) The ~~MCO~~ MCE has established a grievance procedure pursuant to the provisions in section 25.5-5-406 (1) (b) that allows for the timely resolution of disputes regarding the quality of care, services to be provided, and other issues raised by the recipient. Matters shall be resolved in a manner consistent with the medical needs of the individual recipient. The ~~MCO~~ MCE shall notify all recipients involved in a dispute with the ~~MCO~~ MCE of their right to seek an administrative review of an adverse decision made by the ~~MCO~~ MCE pursuant to section 25.5-1-107.

(p) With respect to pregnant women and infants, the ~~MCO~~ MCE shall comply with the following:

(I) WITH THE EXCEPTION OF BHOS, enrollment of pregnant women without restrictions and including an assurance that the health care provider shall provide timely access to initiation of prenatal care in accordance with practice standards;

(II) WITH THE EXCEPTION OF BHOS, coverage without restrictions for newborns, including ALL services such as, but not limited to, preventive care, screening, and well-baby examinations during the first month of life;

(III) WITH THE EXCEPTION OF BHOS, the imposition of performance standards and the use of quality indicators with respect to perinatal, prenatal, and postpartum care for women and birthing and neonatal care for infants. The standards and indicators shall be based on nationally approved guidelines.

(IV) WITH THE EXCEPTION OF BHOS, follow-up basic health maintenance services for women and children, including immunizations and early periodic screening, diagnosis, and treatment services for children and appropriate preventive

care services for women.

(q) The ~~MCO~~ MCE shall accept all enrollees regardless of health status.

(r) The ~~MCO~~ MCE shall comply with disclosure requirements as established by the state department and the state board.

(s) The ~~MCO~~ MCE shall provide a mechanism whereby a prescribing physician can request to override restrictions to obtain medically necessary, off-formulary prescription drugs, supplies, equipment, or services for his or her patient.

(t) The ~~MCO~~ MCE shall maintain a network of providers sufficient to ~~assure~~ ENSURE that all services to recipients will be accessible without unreasonable delay. The state department shall develop explicit contract standards, in consultation with stakeholders, to assess and monitor the ~~MCO's~~ MCE'S criteria. Sufficiency shall be determined in accordance with the requirements of this paragraph (t) and may be established by reference to any reasonable criteria used by the ~~MCO~~ MCE, including but not limited to the following:

(I) Geographic accessibility in regard to the special needs of recipients;

(II) Waiting times for appointments with participating providers;

(III) Hours of operation;

(IV) Volume of technological and specialty services available to serve the needs of recipients requiring technologically advanced or specialty care.

(u) (I) For the delivery of prescription drug benefits to recipients enrolled in an ~~MCO~~ MCE who are residents of a nursing facility, ~~MCOs~~ MCES THAT PROVIDE PRESCRIPTION DRUG BENEFIT SERVICES shall use pharmacies with a demonstrated capability of providing prescription drugs in a manner consistent with the needs of clients in institutional settings such as nursing facilities. In cases where a nursing facility and a pharmacy have a contract for a single pharmacy delivery system for residents of the nursing facility:

(A) An ~~MCO~~ MCE providing prescription drug benefits for residents of the nursing facility shall agree to contract with that pharmacy under reasonable contract terms; and

(B) The pharmacy shall agree to contract with each ~~MCO~~ MCE that provides prescription drug benefits for residents of the nursing facility under reasonable contract terms.

(II) Any disputes concerning providing prescription drug benefits between nursing facilities, pharmacies, and ~~MCOs~~ MCES that cannot be resolved through good faith negotiations may be resolved through a party requesting an informal review by the state department.

(III) The state board shall adopt rules requiring ~~MCOs~~ MCES THAT PROVIDE PRESCRIPTION DRUG BENEFIT SERVICES to contract with qualified pharmacy

providers in a manner permitting a nursing facility to continue to comply with federal medicaid requirements of participation for nursing facilities. Such rules shall define "qualified pharmacy providers" and shall be based upon consultations with nursing facilities, ~~MCOs~~ MCEs, pharmacies, and medicaid clients. The state department shall provide ~~MCOs~~ MCEs with a list of pharmacies that have a contract with nursing facilities serving recipients in nursing facilities in each county in which the ~~MCO~~ MCE is contracting with the state department.

(2) The ~~MCO~~ MCE shall seek proposals from each ECP in a county in which the ~~MCO~~ MCE is enrolling recipients for those services that the ~~MCO~~ MCE provides or intends to provide and that an ECP provides or is capable of providing. To assist ~~MCOs~~ MCEs in seeking proposals, the state department shall provide ~~MCOs~~ MCEs with a list of ECPs in each county. The ~~MCO~~ MCE shall consider such proposals in good faith and shall, when deemed reasonable by the ~~MCO~~ MCE based on the needs of its enrollees, contract with ECPs. Each ECP shall be willing to negotiate on reasonably equitable terms with each ~~MCO~~ MCE. ECPs making proposals under this subsection (2) must be able to meet the contractual requirements of the ~~MCO~~ MCE. The requirements of this subsection (2) shall not apply to an ~~MCO~~ MCE in areas in which the ~~MCO~~ MCE operates entirely as a group model health maintenance organization.

(3) In selecting ~~MCOs~~ MCEs, the state department shall not penalize an ~~MCO~~ MCE for paying cost-based reimbursement to federally qualified health centers as defined in the "Social Security Act".

(4) (a) Notwithstanding any waivers authorized by the federal department of health and human services, or any successor agency, each contract between the state department and an ~~MCO~~ MCE selected to participate in the statewide managed care system under this part 4 shall comply with the requirements of 42 U.S.C. sec. 1396a (a) (23) (B).

(b) Each ~~MCO~~ MCE shall advise its enrollees of the services available pursuant to this subsection (4).

(5) Nothing in this part 4 shall be construed to create an exemption from the applicable provisions of title 10, C.R.S.

(6) Nothing in this part 4 shall be construed to create an entitlement to an ~~MCO~~ MCE to contract with the state department.

SECTION 4. 25.5-5-406, Colorado Revised Statutes, is amended to read:

25.5-5-406. 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 state board consider necessary for the effective and cost-efficient operation of those programs:

(a) **Recipient selection of MCEs.** (I) The state department shall, to the extent it determines feasible, provide medicaid-eligible recipients a choice among competing ~~MCOs. MCOs~~ MCEs. MCEs shall provide enrollees a choice among providers within the ~~MCO~~ MCE. Consistent with federal requirements and rules

promulgated by the state board, the state department is authorized to assign a medicaid recipient to a particular ~~MCO~~ MCE or ~~primary care physician~~ PCCM if:

(A) The state department determines that no other ~~MCO~~ MCE or ~~primary care physician~~ PCCM has the capacity or expertise necessary to serve the recipient; or

(B) A recipient does not respond within thirty days after the date of a notification of a request for selection of an ~~MCO~~ MCE or ~~primary care physician~~ PCCM.

(II) The state department shall inform recipients of the choices available in their area by appropriate sources of information and counseling. This may include an independent, objective facilitator acting under the supervision of the state department. The state department may 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 state department, in conjunction with the state board, shall adopt rules setting forth minimum disclosure requirements for all ~~MCOs~~ MCES AND PCCMS. Once a recipient is enrolled in an ~~MCO~~ MCE OR PCCM, the recipient may not change to a different ~~MCO~~ MCE OR PCCM for a period of 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~~ MCE'S OR PCCM'S inability to provide its covered services to a recipient after reasonable efforts on the part of the ~~MCO~~ MCE OR PCCM and the recipient, as defined by the state board. Based upon its assessment of any special needs of recipients with cognitive disabilities, the state board may adopt rules relating to any necessary good cause provisions for recipients with cognitive disabilities who are assigned to a particular ~~MCO~~ MCE OR PCCM pursuant to subparagraph (I) of this paragraph (a).

(III) When eligible consumers choose to change or disenroll from their selected ~~MCO~~ MCE OR PCCM, 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~~ MCE OR PCCM. 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~~ MCE OR PCCM may seek review by an independent hearing officer, as provided for and required under federal law and any state statute or rule.

(b) **Complaints and grievances.** Each ~~MCO~~ MCE OR PCCM shall utilize a complaint and grievance procedure and a process for expedited reviews that comply with rules established by the state board. The complaint and grievance procedure shall provide a means by which enrollees may complain about or grieve any action or failure to act that impacts an enrollee's access to, satisfaction with, or the quality of health care services, treatments, or providers. The state department shall establish the position of ombudsman for medicaid managed care. It is the intent of the general assembly that the ombudsman for medicaid managed care be independent from the state department and selected through a competitive bidding process. In the event the state department is unable to contract with an independent ombudsman, an employee of the state department may serve as the ombudsman for

medicaid managed care. The ombudsman shall, if the enrollee requests, act as the enrollee's representative in resolving complaints and grievances with the ~~MCO~~ MCE OR PCCM. The process for expedited reviews shall provide a means by which an enrollee may complain and seek resolution concerning any action or failure to act in an emergency situation that immediately impacts the enrollee's access to quality health care services, treatments, or providers. An enrollee shall be entitled to designate a representative, including but not limited to an attorney, the ombudsman for medicaid managed care, a lay advocate, or the enrollee's physician, to file and pursue a grievance or expedited review on behalf of the enrollee. The procedure shall allow for the unencumbered participation of physicians. An enrollee whose complaint or grievance is not resolved to his or her satisfaction by a procedure described in this paragraph (b) or who chooses to forego a procedure described in this paragraph (b) shall be entitled to request a second-level review by an independent hearing officer, further judicial review, or both, as provided for by federal law and any state statute or rule. The state department may also provide by rule for arbitration as an optional alternative to the complaint and grievance procedure set forth is this paragraph (b) to the extent that such rules do not violate any other state or federal statutory or constitutional requirements.

(c) **Billing medicaid recipients.** Notwithstanding any federal regulations or the general prohibition of section 25.5-4-301 against providers billing medicaid recipients, a provider may bill a medicaid recipient who is enrolled with a specific medicaid ~~primary care physician~~ PCCM or ~~MCO~~ MCE and, in circumstances defined by the rules of the state board, receives care from a medical provider outside that organization's network or without referral by the recipient's ~~primary care physician~~ PCCM.

(d) **Marketing.** In marketing coverage to medicaid recipients, all ~~MCOs~~ MCES shall comply with all applicable provisions of title 10, C.R.S., regarding health plan marketing. The state board is authorized to promulgate rules concerning the permissible marketing of medicaid managed care. The purposes of such rules shall include but not be limited to the avoidance of biased selection among the choices available to medicaid recipients.

(e) **Prescription drugs.** All ~~MCOs~~ MCES THAT HAVE PRESCRIPTION DRUGS AS A COVERED BENEFIT shall provide prescription drug coverage in accordance with the provisions of section 25.5-5-202 (1) (a) as part of a comprehensive health benefit and with respect to any formulary or other access restrictions:

(I) The ~~MCO~~ MCE shall supply participating providers who may prescribe prescription drugs for ~~MCO~~ MCE enrollees with a current copy of such formulary or other access restrictions, including information about coverage, payment, or any requirement for prior authorization; and

(II) The ~~MCO~~ MCE shall provide to all medicaid recipients at periodic intervals, and prior to and during enrollment upon request, clear and concise information about the prescription drug program in language understandable to the medicaid recipients, including information about such formulary or other access restrictions and procedures for gaining access to prescription drugs, including off-formulary products.

(f) **Access to prescription drugs.** (I) The state department shall encourage an ~~MCO~~ MCE to solicit competitive bids for the prescription drug benefit and discourage an ~~MCO~~ MCE THAT HAS PRESCRIPTION DRUGS AS A COVERED BENEFIT from contracting for the prescription drug benefit with a sole source provider as much as possible. The state department's reports required by section 25.5-5-410 shall include a summary of each ~~MCO's~~ MCE'S pharmacy network by geographic catchment area.

(II) If an ~~MCO~~ MCE solicits competitive bids for the prescription drug benefit, the ~~MCO~~ MCE shall request bids from each pharmacy provider located in the geographic areas in which the ~~MCO~~ MCE is soliciting bids. All ~~MCOs~~ MCES shall follow a reasonable standard for recipient access to prescription drugs. At a minimum, the state department shall verify compliance with these requirements by reviewing evidence provided by the commissioner of insurance concerning compliance with any standards or guidance established by the commissioner of insurance for consumer access to prescription drugs.

(III) The standards and guidance from the insurance commissioner shall be based on the following:

(A) Procedures that an ~~MCO~~ MCE shall follow to ensure that pharmacies in rural communities with fewer than twenty-five thousand persons have the opportunity to join retail prescription drug networks if they agree to reasonable contract terms;

(B) Procedures that an ~~MCO~~ MCE shall follow to notify the pharmacy community of competitively bid prescription drug contracts;

(C) Procedures that an ~~MCO~~ MCE shall follow to give all pharmacies and pharmacy networks a fair opportunity to participate in prescription drug contracts;

(D) Any related matters that are designed to expand consumer access to pharmacy services; and

(E) Any related matters that will enhance the functioning of the free market system with respect to pharmacies.

(IV) Nothing in this paragraph (f) shall apply to the delivery of prescription drug benefits to recipients enrolled in an ~~MCO~~ MCE who are residents of a nursing facility or to the delivery of medicare part D prescription drugs to recipients who are eligible for such drugs.

(g) **Continuity of care.** (I) New enrollees, with special needs as defined by the state board and as certified by a non-plan physician, may continue to see a non-plan provider for sixty days from the date of enrollment in an ~~MCO~~ MCE, if the enrollee is in an ongoing course of treatment with the previous provider and only if the previous provider agrees:

(A) To accept reimbursement from the ~~MCO~~ MCE as payment in full at rates established by the ~~MCO~~ MCE that shall be no more than the level of reimbursement applicable to similar providers within the ~~MCO's~~ MCE'S group or network for such services;

(B) To adhere to the ~~MCO's~~ MCE'S quality assurance requirements and to provide to the ~~MCO~~ MCE necessary medical information related to such care; and

(C) To otherwise adhere to the ~~MCO's~~ MCE'S policies and procedures including but not limited to procedures regarding referrals, obtaining pre-authorizations, and ~~MCO~~ MCE-approved treatment plans.

(II) New enrollees who are in their second or third trimester of pregnancy may continue to see their practitioner until the completion of post-partum care directly related to the delivery only if the practitioner agrees:

(A) To accept reimbursement from the ~~MCO~~ MCE as payment in full at rates established by the ~~MCO~~ MCE that shall be no more than the level of reimbursement applicable to similar providers within the ~~MCO's~~ MCE'S group or network for such services;

(B) To adhere to the ~~MCO's~~ MCE'S quality assurance requirements and to provide to the ~~MCO~~ MCE necessary medical information related to such care; and

(C) To otherwise adhere to the ~~MCO~~ MCE's policies and procedures including but not limited to procedures regarding referrals, obtaining pre-authorizations, and ~~MCO~~ MCE-approved treatment plans.

(III) New enrollees with special needs as defined by the state department may continue to see ancillary providers at the level of care received prior to enrollment for a period of up to seventy-five days. The terms and conditions, including reimbursement rates, shall remain the same as prior to enrollment if the provider and enrollee agree to work in good faith with the ~~MCO~~ MCE toward a transition.

(IV) This paragraph (g) shall not be construed to require an ~~MCO~~ MCE to provide coverage for benefits not otherwise covered.

SECTION 5. 25.5-5-408 (1) (a), (2), (6), (7), (8), (9), (10), and (12), Colorado Revised Statutes, are amended to read:

25.5-5-408. Capitation payments - availability of base data - adjustments - rate calculation - capitation payment proposal - preference - assignment of medicaid recipients. (1) (a) The state department shall make prepaid capitation payment to ~~managed care organizations~~ MCES based upon a defined scope of services UNDER A RISK CONTRACT.

(2) The state department shall develop capitation rates for ~~MCOs~~ MCES CONTRACTING FOR A DEFINED SCOPE OF SERVICES UNDER A RISK CONTRACT that include risk adjustments, reinsurance, or stop-loss funding methods. Payments to plans may vary when it is shown through diagnoses or other relevant data that certain populations are expected to cost more or less than the capitated population as a whole.

(6) Within thirty days from the beginning of each fiscal year, the state department, in cooperation with the ~~MCOs~~ MCES, shall set a timeline for the rate-setting process for the following fiscal year's rates and for the provision of base

data to the ~~MCOs~~ MCES that is used in the calculation of the rates, which shall include but not be limited to the information included in subsection (7) of this section.

(7) The state department shall identify and make available to the ~~MCOs~~ MCES the base data used in the calculation 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 consult with the ~~MCOs~~ MCES regarding any and all adjustments in the base data made to arrive at the capitation payments.

(8) For capitation payments effective on and after July 1, 2003, the state department shall recalculate the base calculation every three years. The three-year cycle for the recalculation of the base calculation shall begin with capitation payments effective for fiscal year 2003-04. In the years in which the base calculation is not recalculated, the state department shall annually trend the base calculation after consulting with the ~~MCOs~~ MCES. The state department shall take into consideration when trending the base calculation any public policy changes that affect reimbursement under the "Colorado Medical Assistance Act".

(9) The rate-setting process referenced in subsection (6) of this section shall include a time period after the ~~MCOs~~ MCES 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~~ MCE to submit to the state department the ~~MCO's~~ MCE'S capitation payment proposal, which shall not exceed 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~~ MCES the ~~MCO's~~ MCE'S specific adjustments to be included in the calculation of the ~~MCO's~~ MCE'S proposal. Each ~~MCO's~~ MCE'S capitation payment proposal shall meet the requirements of section 25.5-5-404 (1) (k) and (1) (l).

(10) For capitation payments effective on and after July 1, 2003, unless otherwise required by federal law, the state department shall certify, through a qualified actuary retained by the state department, that the capitation payments set forth in the contract between the state department and the ~~MCOs~~ MCES comply with all applicable federal and state requirements that govern said capitation payments.

(12) Nothing in this section shall prevent, to the extent possible, an ~~MCO~~ MCE 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 6. 25.5-5-410 (1), Colorado Revised Statutes, is amended to read:

25.5-5-410. Data collection for managed care programs - reports. (1) In addition to any other data collection or reporting requirements set forth in this article and articles 4 and 6 of this title, the state department shall access and compile data concerning health data and outcomes. In addition, no later than July 1, 1998, the state department shall conduct or shall contract with an independent evaluator to conduct a quality assurance analysis of each managed care program in the state for medical assistance recipients. No later than July 1, 1999, and each fiscal year thereafter, the state department, using the compiled data and results from the quality assurance analysis, shall submit a report to the house and senate committees on health and human services, or any successor committees, on the cost-efficiency of each managed care program or component thereof, with recommendations concerning statewide implementation of the respective programs or components. For the purposes of this subsection (1), "quality assurance" means costs weighed against benefits provided to consumers, health outcomes or maintenance of the individual's highest level of functioning, and the overall change in the health status of the population served. The state department's report shall address capitation, including methods for adjusting rates based on risk allocations, fees-for-services, copayments, chronically ill populations, long-term care, community-supported services, and the entitlement status of medical assistance. The state department's report shall include a comparison of the effectiveness of the ~~MCO~~ MCE program and the ~~primary care physician~~ PCCM program based upon common performance standards that shall include but not be limited to recipient satisfaction.

SECTION 7. 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, (August 6, 2008, if adjournment sine die is on May 7, 2008); 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: April 10, 2008