CHAPTER 5

HEALTH CARE POLICY AND FINANCING

HOUSE BILL 12-1203

BY REPRESENTATIVE(S) Gerou, Becker, Levy, Labuda, Summers, Todd, Young;
also SENATOR(S) Steadman, Hodge, Lambert, Aguilar.

AN ACT

CONCERNING THE REENACTMENT OF THE STATUTES THAT AUTHORIZE GRANTS FROM THE PRIMARY CARE FUND FOR COMPREHENSIVE PRIMARY CARE SERVICES.

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

SECTION 1. In Colorado Revised Statutes, **recreate and reenact, with amendments,** part 3 of article 3 of title 25.5 as follows:

PART 3
COMPREHENSIVE PRIMARY CARE SERVICES

25.5-3-301. Definitions. AS USED IN THIS PART 3, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(1) "COMPREHENSIVE PRIMARY CARE" MEANS THE BASIC, ENTRY-LEVEL HEALTH CARE PROVIDED BY HEALTH CARE PRACTITIONERS OR NON-PHYSICIAN HEALTH CARE PRACTITIONERS THAT IS GENERALLY PROVIDED IN AN OUTPATIENT SETTING. "COMPREHENSIVE PRIMARY CARE", AT A MINIMUM, INCLUDES PROVIDING OR ARRANGING FOR THE PROVISION OF THE FOLLOWING SERVICES ON A YEAR-ROUND BASIS: PRIMARY HEALTH CARE; MATERNITY CARE, INCLUDING PRENATAL CARE; PREVENTIVE, DEVELOPMENTAL, AND DIAGNOSTIC SERVICES FOR INFANTS AND CHILDREN; ADULT PREVENTIVE SERVICES, DIAGNOSTIC LABORATORY AND RADIOLOGY SERVICES; EMERGENCY CARE FOR MINOR TRAUMA; PHARMACEUTICAL SERVICES; AND COORDINATION AND FOLLOW-UP FOR HOSPITAL CARE. "COMPREHENSIVE PRIMARY CARE" MAY ALSO INCLUDE OPTIONAL SERVICES BASED ON A PATIENT'S NEEDS. FOR THE PURPOSES OF THIS SUBSECTION (1) AND SUBSECTION (2) OF THIS SECTION, "ARRANGING FOR THE PROVISION" MEANS DEMONSTRATING ESTABLISHED REFERRAL RELATIONSHIPS WITH HEALTH CARE PROVIDERS FOR ANY OF THE COMPREHENSIVE PRIMARY CARE SERVICES NOT DIRECTLY PROVIDED BY AN

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

ENTITY. AN ENTITY IN A RURAL AREA MAY BE EXEMPT FROM THIS REQUIREMENT IF IT CAN DEMONSTRATE THAT THERE ARE NO PROVIDERS IN THE COMMUNITY TO PROVIDE ONE OR MORE OF THE COMPREHENSIVE PRIMARY CARE SERVICES.

(2) "QUALIFIED PROVIDER" MEANS AN ENTITY THAT PROVIDES COMPREHENSIVE PRIMARY CARE SERVICES AND THAT:

(a) ACCEPTS ALL PATIENTS REGARDLESS OF THEIR ABILITY TO PAY AND USES A SLIDING FEE SCHEDULE FOR PAYMENTS OR THAT PROVIDES COMPREHENSIVE PRIMARY CARE SERVICES FREE OF CHARGE;

(b) SERVES A DESIGNATED MEDICALLY UNDERSERVED AREA OR POPULATION, AS PROVIDED IN SECTION 330(b) OF THE FEDERAL "PUBLIC HEALTH SERVICE ACT", 42 U.S.C. SEC. 254b, OR DEMONSTRATES TO THE STATE DEPARTMENT THAT THE ENTITY SERVES A POPULATION OR AREA THAT LACKS ADEQUATE HEALTH CARE SERVICES FOR LOW-INCOME, UNINSURED PERSONS;

(c) HAS A DEMONSTRATED TRACK RECORD OF PROVIDING COST-EFFECTIVE CARE;

(d) PROVIDES OR ARRANGES FOR THE PROVISION OF COMPREHENSIVE PRIMARY CARE SERVICES TO PERSONS OF ALL AGES; AND

(e) COMPLETES INITIAL SCREENING FOR ELIGIBILITY FOR THE STATE MEDICAL ASSISTANCE PROGRAM, THE CHILDREN'S BASIC HEALTH PLAN, AND ANY OTHER RELEVANT GOVERNMENT HEALTH CARE PROGRAM AND REFERRAL TO THE APPROPRIATE AGENCY FOR ELIGIBILITY DETERMINATION.

(3) "UNINSURED OR MEDICALLY INDIGENT PATIENT" MEANS A PATIENT RECEIVING SERVICES FROM A QUALIFIED PROVIDER:

(a) WHOSE YEARLY FAMILY INCOME IS BELOW TWO HUNDRED PERCENT OF THE FEDERAL POVERTY LINE; AND

(b) WHO IS NOT ELIGIBLE FOR MEDICAID, MEDICARE, OR ANY OTHER TYPE OF GOVERNMENTAL REIMBURSEMENT FOR HEALTH CARE COSTS; AND

(c) WHO IS NOT RECEIVING THIRD-PARTY PAYMENTS.

25.5-3-302. Annual allocation - primary care services - qualified provider - rules. (1) THE STATE DEPARTMENT SHALL ANNUALLY ALLOCATE THE MONEYS APPROPRIATED BY THE GENERAL ASSEMBLY TO THE PRIMARY CARE FUND CREATED IN SECTION 24-22-117 (2) (b), C.R.S., TO ALL ELIGIBLE QUALIFIED PROVIDERS IN THE STATE WHO COMPLY WITH THE REQUIREMENTS OF SUBSECTION (2) OF THIS SECTION. THE STATE DEPARTMENT SHALL ALLOCATE THE MONEYS IN AMOUNTS PROPORTIONATE TO THE NUMBER OF UNINSURED OR MEDICALLY INDIGENT PATIENTS SERVED BY THE QUALIFIED PROVIDER. FOR A QUALIFIED PROVIDER TO BE ELIGIBLE FOR AN ALLOCATION PURSUANT TO THIS SECTION, THE QUALIFIED PROVIDER SHALL MEET EITHER OF THE FOLLOWING CRITERIA:

(a) THE QUALIFIED PROVIDER IS A COMMUNITY HEALTH CENTER, AS DEFINED IN SECTION 330 OF THE FEDERAL "PUBLIC HEALTH SERVICE ACT", 42 U.S.C. SEC. 254b;

OR

(b) AT LEAST FIFTY PERCENT OF THE PATIENTS SERVED BY THE QUALIFIED PROVIDER ARE UNINSURED OR MEDICALLY INDIGENT PATIENTS, OR PATIENTS WHO ARE ENROLLED IN THE MEDICAL ASSISTANCE PROGRAM, ARTICLES 4, 5, AND 6 OF THIS TITLE, OR THE CHILDREN'S BASIC HEALTH PLAN, ARTICLE 8 OF THIS TITLE, OR ANY COMBINATION THEREOF.

(2) A QUALIFIED PROVIDER SHALL ANNUALLY SUBMIT TO THE STATE DEPARTMENT INFORMATION SUFFICIENT TO ESTABLISH THE PROVIDER'S ELIGIBILITY STATUS. A QUALIFIED PROVIDER, EXCEPT FOR A PROVIDER SPECIFIED IN PARAGRAPH (a) OF SUBSECTION (1) OF THIS SECTION, SHALL PROVIDE AN ANNUAL REPORT THAT INCLUDES THE TOTAL NUMBER OF PATIENTS SERVED, THE NUMBER OF UNINSURED OR MEDICALLY INDIGENT PATIENTS SERVED, AND THE NUMBER OF PATIENTS SERVED WHO ARE ENROLLED IN THE MEDICAL ASSISTANCE PROGRAM, ARTICLES 4, 5, AND 6 OF THIS TITLE, OR THE CHILDREN'S BASIC HEALTH PLAN, ARTICLE 8 OF THIS TITLE. A COMMUNITY HEALTH CENTER SPECIFIED IN PARAGRAPH (a) OF SUBSECTION (1) OF THIS SECTION SHALL ANNUALLY PROVIDE TO THE STATE DEPARTMENT THE NUMBER OF UNINSURED OR MEDICALLY INDIGENT PATIENTS SERVED. EACH ELIGIBLE QUALIFIED PROVIDER SHALL ANNUALLY DEVELOP AND SUBMIT TO THE STATE DEPARTMENT DOCUMENTATION REGARDING THE QUALITY ASSURANCE PROGRAM IN PLACE AT THE PROVIDER'S FACILITY TO ENSURE THAT QUALITY COMPREHENSIVE PRIMARY CARE SERVICES ARE BEING PROVIDED. ALL QUALIFIED PROVIDERS SHALL SUBMIT TO THE STATE DEPARTMENT THE INFORMATION REQUIRED UNDER THIS SECTION, AS SPECIFIED IN RULE BY THE STATE BOARD. THE DATA REGARDING THE NUMBER OF PATIENTS SERVED SHALL BE VERIFIED BY AN OUTSIDE ENTITY. FOR PURPOSES OF THIS PART 3, THE NUMBER OF PATIENTS SERVED IS THE NUMBER OF UNDUPLICATED USERS OF HEALTH CARE SERVICES AND IS NOT THE NUMBER OF VISITS BY A PATIENT.

(3) THE STATE DEPARTMENT SHALL MAKE ANNUAL DIRECT ALLOCATIONS OF THE TOTAL AMOUNT OF MONEY ANNUALLY APPROPRIATED BY THE GENERAL ASSEMBLY TO THE PRIMARY CARE FUND PURSUANT TO SECTION 24-22-117 (2) (b), C.R.S., MINUS THREE PERCENT FOR THE ADMINISTRATIVE COSTS OF THE PROGRAM, TO ALL ELIGIBLE QUALIFIED PROVIDERS. AN ELIGIBLE QUALIFIED PROVIDER'S ALLOCATION SHALL BE BASED ON THE NUMBER OF UNINSURED OR MEDICALLY INDIGENT PATIENTS SERVED BY THE PROVIDER IN PROPORTION TO THE TOTAL NUMBER OF UNINSURED OR MEDICALLY INDIGENT PATIENTS SERVED BY ALL ELIGIBLE QUALIFIED PROVIDERS IN THE PREVIOUS CALENDAR YEAR. THE STATE DEPARTMENT SHALL ESTABLISH A SCHEDULE FOR ALLOCATING THE MONEYS IN THE PRIMARY CARE FUND FOR ELIGIBLE QUALIFIED PROVIDERS. THE DISBURSEMENT OF MONEYS IN THE PRIMARY CARE FUND TO ELIGIBLE QUALIFIED PROVIDERS UNDER THIS PART 3 ARE EXEMPT FROM THE PROVISIONS OF THE "PROCUREMENT CODE", ARTICLES 101 TO 112 OF TITLE 24, C.R.S.

(4) THE STATE BOARD SHALL ADOPT ANY RULES NECESSARY FOR THE ADMINISTRATION AND IMPLEMENTATION OF THIS PART 3.

25.5-3-303. Consultation. AT LEAST ANNUALLY, THE STATE DEPARTMENT SHALL CONSULT WITH REPRESENTATIVES OF FEDERALLY QUALIFIED HEALTH CENTERS, SCHOOL-BASED HEALTH CENTERS, FAMILY RESIDENCY DIRECTORS, CERTIFIED RURAL

HEALTH CLINICS, OTHER QUALIFIED PROVIDERS, AND CONSUMER ADVOCATES REGARDING THE IMPLEMENTATION AND ADMINISTRATION OF THE ALLOCATION OF MONEYS TO QUALIFIED PROVIDERS UNDER THIS PART 3.

SECTION 2. 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: March 1, 2012