Second Regular Session
Seventy-first General Assembly
STATE OF COLORADO

PREAMENDED

This Unofficial Version Includes Committee Amendments Not Yet Adopted on Second Reading

LLS NO. 18-0170.01 Brita Darling x2241 **HOUSE BILL 18-1431**

HOUSE SPONSORSHIP

Ginal,

SENATE SPONSORSHIP

Smallwood,

House Committees
Health, Insurance, & Environment

Senate Committees
Finance

A BILL FOR AN ACT

101 CONCERNING UPDATING MANAGED CARE PROVISIONS IN THE MEDICAL
102 ASSISTANCE PROGRAM, AND, IN CONNECTION THEREWITH,
103 ALIGNING MANAGED CARE PROVISIONS WITH NEW FEDERAL
104 MANAGED CARE REGULATIONS, REMOVING OBSOLETE OR
105 DUPLICATIVE STATUTORY LANGUAGE AND PROGRAMS, AND
106 UPDATING AND ALIGNING STATUTORY PROVISIONS TO REFLECT
107 THE CURRENT STATEWIDE MANAGED CARE SYSTEM.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov.)

HOUSE
3rd Reading Unamended
May 7, 2018

HOUSE
2nd Reading Unamended
May 4, 2018

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.
Capital letters or bold & italic numbers indicate new material to be added to existing statute.
Dashes through the words indicate deletions from existing statute.

The bill amends, repeals, and relocates provisions of part 4 of article 5 of title 25.5, Colorado Revised Statutes, relating to managed care provisions under the medical assistance program to align with the federal "Medicaid and CHIP Managed Care Final Rule of 2016", and to reflect the implementation of the accountable care collaborative as the statewide managed care system.

The bill:

- Updates the definition of the statewide managed care system and makes conforming amendments throughout the statutes;
- Integrates medicaid community mental health services into the statewide managed care system;
- Includes capitated rates specifically for community mental health services;
- Establishes the medical home model of care for the statewide managed care system;
- Relocates provisions relating to graduate medical education;
- Clarifies that the statewide managed care system is authorized to provide services under a single managed care entity (MCE) or a combination of MCE types, including primary care case management entities authorized under federal law;
- Removes duplicate provisions relating to the medicaid reform and innovation pilot program;
- Relocates provisions relating to the requirement that MCEs certify capitation payments as sufficient;
- Removes outdated language referencing behavioral health organizations;
- Updates the definitions for "managed care" and "managed care entities" and adds definitions for "medical home" and "primary care case management entities";
- Aligns provisions in statutes relating to the features of MCEs with new and existing federal managed care regulations that require:
  - Criteria for accepting enrollees and protecting enrollees from discrimination;
  - Provisions relating to network adequacy standards;
  - Revised communication standards;
  - Updated provisions relating to grievances and appeals;
  - Participation in a comprehensive quality assessment and performance improvement program; and
  - Administration of a program integrity system;

- Removes certain provisions from statute relating to prescription drug contracting practices that were relevant to a competitive managed care organization model or that duplicated provisions established in rule;
- Removes references to the obsolete primary care physician program;
- Increases the timeline for the rate setting process for capitation rates to meet new federal review requirements;
- Repeals statutory sections that contain provisions that are relocated or revised and included in other statutory sections in the bill, and repeals statutory sections that include obsolete programs or policies; and
- Updates statutory references to reflect the relocated, revised, or repealed provisions.

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

2 **SECTION 1.** In Colorado Revised Statutes, **amend with**
3 **amended and relocated provisions** 25.5-5-402 as follows:

4 **25.5-5-402. Statewide managed care system - definition.**
5 (1) The state board shall adopt rules to implement a STATEWIDE managed
6 care system for Colorado medical assistance ~~clients~~ RECIPIENTS pursuant
7 to the provisions of this ~~article~~ ARTICLE 5 and articles 4 and 6 of this ~~title~~
8 TITLE 25.5. The statewide managed care system shall be implemented to
9 the extent possible.

10 (2) The STATEWIDE managed care system implemented pursuant
11 to this ~~article shall~~ ARTICLE 5 DOES not include:

12 (a) The services delivered under the residential child health care
13 program described in section 25.5-5-306, except in those counties in
14 which there is a written agreement between the county department of
15 HUMAN OR social services, the designated and contracted ~~behavioral~~
16 ~~health organization selected pursuant to section 25.5-5-411~~ MCE
17 RESPONSIBLE FOR COMMUNITY BEHAVIORAL HEALTH CARE, and the state

department;

(b) Long-term care services and the program of all-inclusive care for the elderly, as described in section 25.5-5-412. For purposes of this subsection (2), "long-term care services" means nursing facilities and home- and community-based services provided to eligible clients who have been determined to be in need of such services pursuant to the "Colorado Medical Assistance Act" and the state board's rules.

(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 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.~~ THE STATEWIDE MANAGED CARE SYSTEM MUST INCLUDE A STATEWIDE SYSTEM OF COMMUNITY BEHAVIORAL HEALTH CARE THAT MUST:

(a) **[Formerly 25.5-5-411 (1)(a)]** ~~There is an urgent need to~~ Address the economic, social, and personal costs to the state of Colorado and its citizens of untreated BEHAVIORAL HEALTH DISORDERS, INCLUDING mental health and substance use disorders;

(b) **[Formerly 25.5-5-411 (1)(b)]** APPROACH behavioral health disorders ~~including mental health and substance use disorders, are~~ AS treatable conditions not unlike other chronic health issues that require a combination of behavioral change and medication or other treatment; ~~When individuals receive appropriate prevention, early intervention,~~

~~treatment, and recovery services, they can live full, productive lives.~~

(c) **[Formerly 25.5-5-411 (1)(f)]** OFFER timely access through multiple points of entry to a full continuum of culturally responsive BEHAVIORAL HEALTH services, including prevention, early intervention, crisis response, treatment, and recovery ~~is necessary for an effective integrated system~~ SERVICES, THAT SUPPORT INDIVIDUALS LIVING FULL, PRODUCTIVE LIVES;

(d) **[Formerly 25.5-5-411 (1)(e)]** ~~Adult and youth consumers and their families need~~ FEATURE A COMPREHENSIVE AND INTEGRATED SYSTEM OF quality behavioral health care that is individualized and coordinated to meet ~~their~~ INDIVIDUALS' changing needs; ~~through a comprehensive and integrated system;~~ AND

(e) BE PAID FOR BY THE STATE DEPARTMENT ESTABLISHING CAPITATED RATES SPECIFICALLY FOR COMMUNITY MENTAL HEALTH SERVICES THAT ACCOUNT FOR A COMPREHENSIVE CONTINUUM OF NEEDED SERVICES SUCH AS THOSE PROVIDED BY COMMUNITY MENTAL HEALTH CENTERS AS DEFINED IN SECTION 27-66-101;

(f) **[Formerly 25.5-5-411 (1)(j)]** ~~The overarching goal of this behavioral health system transformation shall be to~~ Make the behavioral health system's administrative processes, service delivery, and funding more effective and efficient to improve outcomes for Colorado citizens.

(4) ~~**Waivers.** The implementation of this part 4 is conditioned, to the extent applicable, on the issuance of necessary waivers by the federal government. The provisions of this part 4 shall be implemented to the extent authorized by federal waiver, if so required by federal law~~ THE STATEWIDE MANAGED CARE SYSTEM MUST PROMOTE THE UTILIZATION OF THE MEDICAL HOME MODEL OF CARE FOR ALL ENROLLED MEMBERS. THE

MEDICAL HOME MODEL OF CARE ESTABLISHES A FOCAL POINT OF CARE FOR COMPREHENSIVE PRIMARY CARE AND EFFICIENT COORDINATION WITH SPECIALTY CARE PROVIDERS AND OTHER HEALTH CARE SYSTEMS. THE MEDICAL HOME MODEL HAS PROVEN EFFECTIVE IN PROMOTING EARLY INTERVENTION AND PREVENTION, IMPROVING INDIVIDUALS' HEALTH, AND REDUCING HEALTH CARE COSTS.

(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 MCEs with a contract with the state department under this part 4. GME funding for recipients enrolled in an MCE shall be excluded from the premiums paid to the 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~~ THE STATEWIDE MANAGED CARE SYSTEM BUILDS UPON THE LESSONS LEARNED FROM PREVIOUS MANAGED CARE AND COMMUNITY BEHAVIORAL HEALTH CARE PROGRAMS IN THE STATE IN ORDER TO REDUCE BARRIERS THAT MAY NEGATIVELY IMPACT MEDICAID RECIPIENT EXPERIENCE, MEDICAID RECIPIENT HEALTH, AND EFFICIENT USE OF STATE RESOURCES. THE STATEWIDE MANAGED CARE SYSTEM IS AUTHORIZED TO PROVIDE SERVICES UNDER A SINGLE MCE TYPE OR A COMBINATION OF MCE TYPES.

~~(6) (a) For requests for proposals occurring on and after January 1, 2015, the state department shall allow for payment proposals that include, but need not be limited to, global payment, risk adjustment, risk sharing, and aligned payment incentives, including, but not limited to,~~

~~gainsharing, for health benefits and services provided to medical assistance clients pursuant to sections 25.5-5-404 (1)(k) and (1)(l), 25.5-5-406 (2), and paragraph (b) of subsection (2) of this section.~~

~~(b) The state department shall have the discretion to determine which proposals satisfy the request for proposal, including:~~

~~(I) Whether the proposals are appropriate for the state's coordinated care system; and~~

~~(II) The state department's ability to ensure inpatient and outpatient hospital reimbursements are maximized up to the upper limits, as defined in 42 CFR 447.272 and 42 CFR 447.321 and calculated by the state department periodically.~~

~~(c) The state department may seek any federal waiver necessary to ensure that the effect of the request for proposals does not adversely impact upper payment limits and considerations shall include, but are not limited to, the establishment of an uncompensated care cost pool or a hospital incentive program.~~

(6) **[Formerly 25.5-5-406 (1)(a)(I) introductory portion]** The state department ~~shall, to the extent it determines feasible, provide medicaid-eligible recipients a choice among competing MCEs. MCEs shall provide enrollees a choice among providers within the 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 MCE, ~~or PCCM if:~~ CONSISTENT WITH FEDERAL REQUIREMENTS AND RULES PROMULGATED BY THE STATE BOARD.

(7) THE STATE DEPARTMENT IS AUTHORIZED TO ENTER INTO A CONTRACT WITH MCOS, PCCM ENTITIES, PREPAID AMBULATORY HEALTH PLANS, AND PREPAID INPATIENT HEALTH PLANS, SUBJECT TO THE RECEIPT

OF ANY REQUIRED FEDERAL AUTHORIZATIONS AND PURSUANT TO THE REQUIREMENTS OF THIS SECTION.

(8) **[Formerly 25.5-5-402 (4)] Waivers.** The implementation of this part 4 is conditioned, to the extent applicable, on the issuance of necessary waivers by the federal government. The provisions of this part 4 ~~shall~~ MUST be implemented to the extent authorized by federal waiver, if so required by federal law.

(9) **[Formerly 25.5-5-402 (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 entities~~ MCEs seeking to provide, ~~medical~~ ARRANGE FOR, OR OTHERWISE BE RESPONSIBLE FOR THE PROVISION OF services ~~for medicaid clients eligible to be enrolled in managed care~~ to its ENROLLEES. 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~~ ENCOURAGE COMPETITION AND IMPROVE THE QUALITY OF care ~~choices~~ available to medicaid ~~clients~~ RECIPIENTS over the long term that ~~meet~~ MEETS the requirements of sections ~~25.5-5-404 and 25.5-5-406~~ 25.5-5-402 AND 25.5-5-406.1.

(10) **[Formerly 25.5-5-404 (1)(k)]** ~~Except as provided in paragraph (m) of this subsection (1), for capitation payments effective on and after July 1, 2003,~~ An MCE that is contracting for a defined scope of services under a risk contract shall certify the financial stability of the 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 MCE and the state department are sufficient to ensure the financial~~

1 ~~stability of the MCE with respect to delivery of services to the medicaid~~
2 ~~recipients covered in the contract.~~
3 (11) THE STATE DEPARTMENT SHALL CONDUCT A REVIEW OF EACH
4 MCE, IN ACCORDANCE WITH FEDERAL REQUIREMENTS, PRIOR TO THE
5 IMPLEMENTATION OF A CONTRACT TO ASSESS THE ABILITY AND CAPACITY
6 OF THE MCE TO SATISFACTORILY PERFORM THE OPERATIONAL
7 REQUIREMENTS OF THE CONTRACT.
8 (12) **[Formerly 25.5-5-402 (5)] Graduate medical education.**
9 The state department shall continue the graduate medical education,
10 referred to in this subsection ~~(5)~~ (12) as "GME", funding to teaching
11 hospitals that have graduate medical education expenses in their medicare
12 cost report and are participating as providers under one or more MCEs
13 with a contract with the state department under this part 4. GME funding
14 for recipients enrolled in an MCE ~~shall be~~ IS excluded from the premiums
15 paid to the MCE and ~~shall~~ MUST be paid directly to the teaching hospital.
16 The state board shall adopt rules to implement this subsection ~~(5)~~ (12) and
17 establish the rate and method of reimbursement.
18 (13) **[Formerly 25.5-5-404 (5)]** Nothing in this part 4 ~~shall be~~
19 ~~construed to create~~ CREATES an exemption from the applicable provisions
20 of title 10. ~~C.R.S.~~
21 (14) **[Formerly 25.5-5-404 (6)]** Nothing in this part 4 ~~shall be~~
22 ~~construed to create~~ CREATES an entitlement to an MCE to contract with
23 the state department.
24 **SECTION 2.** In Colorado Revised Statutes, 25.5-5-403, **amend**
25 (2.5), (3)(a), (4), and (8); **repeal** (1); and **add** (5.5) and (7.5) as follows:
26 **25.5-5-403. Definitions.** As used in this part 4, unless the context
27 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.~~

(2.5) "Global payment" means a population-based payment mechanism that is constructed on a per-member, per-month calculation. Global payments ~~shall~~ MUST account for prospective local community or health system cost trends and value, as measured by quality and satisfaction metrics, and ~~shall~~ incorporate community cost experience and reported encounter data to the greatest extent possible to address regional variation and improve longitudinal performance. Risk adjustments, risk-sharing, and aligned payment incentives may be utilized to achieve performance improvement. The rate calculations for global payment are exempt from the provisions of section 25.5-5-408. An entity that uses global payment pursuant to section ~~25.5-5-404~~ 25.5-5-402 shall meet the applicable financial solvency requirements of ~~section 25.5-5-404 (1)(k) and (1)(l)~~ SECTIONS 25.5-5-402 (10) AND 25.5-5-408 (1)(f) and the essential community provider requirements of ~~section 25.5-5-404 (2) and (3)~~ SECTIONS 25.5-5-406.1 (1)(f)(II) AND 25.5-5-408 (1)(d).

(3) (a) "Managed care" means

~~(I)~~ a ~~predefined set of services to recipients delivered by a managed care entity as defined in subsection (4) of this section; or~~ HEALTH CARE DELIVERY SYSTEM ORGANIZED TO MANAGE COSTS, UTILIZATION, AND QUALITY. MEDICAID MANAGED CARE PROVIDES FOR THE DELIVERY OF MEDICAID HEALTH BENEFITS AND ADDITIONAL SERVICES THROUGH CONTRACTED ARRANGEMENTS BETWEEN STATE MEDICAID AGENCIES AND MCES.

~~(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.~~

~~(III) (Deleted by amendment, L. 2008, p. 390, § 2, effective August 5, 2008.)~~

(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~~ THE STATEWIDE managed care system, including ~~managed care organizations~~ MCOS, prepaid inpatient health plans, ~~and~~ prepaid ambulatory health plans, ~~but excluding primary care case managers, as defined in subsection (8) of this section~~ AND PCCM ENTITIES.

(5.5) "MEDICAL HOME" MEANS AN APPROPRIATELY QUALIFIED MEDICAL HEALTH CARE PRACTICE THAT VERIFIABLY ENSURES CONTINUOUS ACCESS TO COMPREHENSIVE, ACCESSIBLE, AND COORDINATED COMMUNITY-BASED PRIMARY CARE. ALL MEDICAL HOMES MAY HAVE, BUT ARE NOT LIMITED TO, THE FOLLOWING:

(a) HEALTH MAINTENANCE AND PREVENTIVE CARE;

(b) ANTICIPATORY GUIDANCE AND HEALTH EDUCATION;

(c) ACUTE AND CHRONIC ILLNESS CARE;

(d) COORDINATION OF MEDICATIONS, SPECIALISTS, AND THERAPIES;

(e) PROVIDER PARTICIPATION IN HOSPITAL CARE; AND

(f) MENTAL HEALTH CARE, ORAL HEALTH CARE, AND OTHER RELATED SERVICES, AS APPROPRIATE.

(7.5) "PRIMARY CARE CASE MANAGEMENT ENTITY", REFERRED TO IN THIS PART 4 AS A "PCCM ENTITY", MEANS AN ENTITY CONTRACTING WITH THE STATE DEPARTMENT THAT MEETS THE DEFINITION OF PRIMARY CARE CASE MANAGEMENT ENTITY 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~~ A PHYSICIAN, A PHYSICIAN GROUP PRACTICE, OR OTHER PRACTITIONER AS IDENTIFIED BY THE STATE that meets the definition of primary care case manager as defined in 42 CFR 438.2.

SECTION 3. In Colorado Revised Statutes, **add with amended and relocated provisions** 25.5-5-406.1 as follows:

25.5-5-406.1. Required features of statewide managed care system. (1) **[Formerly 25.5-5-406 (1) introductory portion] General features.** All medicaid managed care programs ~~shall~~ MUST contain the following general features, in addition to others that the FEDERAL GOVERNMENT, state department, and ~~the~~ state board consider necessary for the effective and cost-efficient operation of those programs:

(a) **[Formerly 25.5-5-404 (1)(q)]** The MCE shall accept all enrollees THAT THE STATE DEPARTMENT ASSIGNS TO THE MCE IN THE ORDER IN WHICH THEY ARE ASSIGNED, WITHOUT RESTRICTION, regardless of health status OR NEED FOR HEALTH CARE SERVICES;

(b) THE MCE SHALL NOT DISCRIMINATE AGAINST ENROLLED MEMBERS ON THE BASIS OF RACE, COLOR, ETHNIC OR NATIONAL ORIGIN, ANCESTRY, AGE, SEX, GENDER, SEXUAL ORIENTATION, GENDER IDENTITY AND EXPRESSION, DISABILITY, RELIGION, CREED, OR POLITICAL BELIEFS, AND SHALL NOT USE ANY POLICY OR PRACTICE THAT HAS THE EFFECT OF DISCRIMINATING ON THE BASIS OF RACE, COLOR, ETHNIC OR NATIONAL ORIGIN, ANCESTRY, AGE, SEX, GENDER, SEXUAL ORIENTATION, GENDER IDENTITY AND EXPRESSION, DISABILITY, RELIGION, CREED, OR POLITICAL BELIEFS;

(c) THE MCE SHALL ALLOW EACH ENROLLED MEMBER TO CHOOSE

1 HIS OR HER NETWORK PROVIDER TO THE EXTENT POSSIBLE AND
2 APPROPRIATE;
3 (d) **[Formerly 25.5-5-404 (4)(a)]** Notwithstanding any waivers
4 authorized by the federal department of health and human services, or any
5 successor agency, each contract between the state department and an
6 MCE selected to participate in the statewide managed care system under
7 this part 4 shall comply with the requirements of 42 U.S.C. sec. 1396a
8 (a)(23)(B);
9 (e) THE MCE SHALL ENSURE ACCESS TO CARE FOR ALL ENROLLED
10 MEMBERS IN NEED OF MEDICALLY NECESSARY SERVICES COVERED IN THE
11 CONTRACT;
12 (f) THE MCE SHALL CREATE, ADMINISTER, AND MAINTAIN A
13 NETWORK OF PROVIDERS, BUILDING ON THE CURRENT NETWORK OF
14 MEDICAID PROVIDERS, TO SERVE THE HEALTH CARE NEEDS OF ITS
15 MEMBERS. IN DOING SO, THE MCE SHALL:
16 (I) SUPPORT PROVIDERS IN SERVING THE MEDICAID POPULATION
17 AND IMPLEMENT VALUE-BASED PAYMENT METHODOLOGIES FOR NETWORK
18 PROVIDERS THAT INCENTIVIZE AND REWARD PROVIDERS FOR THE
19 EFFECTIVE AND EFFICIENT DELIVERY OF HIGH-QUALITY SERVICES TO
20 ENROLLED MEMBERS;
21 (II) **[Formerly 25.5-5-404 (2)]** (A) ~~The MCE shall~~ Seek proposals
22 from each ECP in a county in which the MCE is enrolling recipients for
23 those services that the MCE provides or intends to provide and that an
24 ECP provides or is capable of providing. ~~To assist MCEs in seeking~~
25 ~~proposals, the state department shall provide MCEs with a list of ECPs~~
26 ~~in each county.~~ The MCE shall consider such proposals in good faith and
27 shall, when deemed reasonable by the MCE based on the needs of its

1 enrollees, contract with ECPs. Each ECP shall be willing to negotiate on
2 reasonably equitable terms with each MCE. ECPs making proposals
3 under this subsection ~~(2)~~ (1)(f)(II) must be able to meet the contractual
4 requirements of the MCE. The requirements of this subsection ~~(2) shall~~
5 (1)(f)(II) DO not apply to an MCE in areas in which the MCE operates
6 entirely as a group ~~model~~ health maintenance organization.
7 (B) **[Formerly 25.5-5-404 (3)]** In selecting MCEs, the state
8 department shall not penalize an MCE for paying cost-based
9 reimbursement to federally qualified health centers as defined in the
10 FEDERAL "Social Security Act".
11 (III) DEMONSTRATE THAT THERE ARE SUFFICIENT INDIAN HEALTH
12 CARE PROVIDERS PARTICIPATING IN THE PROVIDER NETWORK TO ENSURE
13 TIMELY ACCESS TO SERVICES AVAILABLE UNDER THE CONTRACT FROM
14 SUCH PROVIDERS FOR INDIAN ENROLLEES WHO ARE ELIGIBLE TO RECEIVE
15 SERVICES.
16 (g) THE MCE SHALL ENSURE THAT ITS CONTRACTED NETWORK
17 PROVIDERS ARE CAPABLE OF SERVING ALL MEMBERS, INCLUDING
18 CONTRACTING WITH PROVIDERS WITH SPECIALIZED TRAINING AND
19 EXPERTISE ACROSS ALL AGES, LEVELS OF ABILITY, GENDER IDENTITIES,
20 AND CULTURAL IDENTITIES;
21 (h) THE MCE SHALL MEET THE NETWORK ADEQUACY STANDARDS,
22 AS ESTABLISHED BY THE STATE DEPARTMENT, DESCRIBING THE MAXIMUM
23 TIME AND DISTANCE AN ENROLLED MEMBER IS EXPECTED TO TRAVEL IN
24 ORDER TO ACCESS THE PROVIDER TYPES COVERED UNDER THE STATE
25 CONTRACT;
26 (i) THE MCE SHALL MEET, AND REQUIRE ITS NETWORK PROVIDERS
27 TO MEET, STANDARDS AS ESTABLISHED BY THE STATE DEPARTMENT FOR

1 TIMELY ACCESS TO CARE AND SERVICES, TAKING INTO ACCOUNT THE
2 URGENCY OF THE NEED FOR SERVICES;

3 (j) **[Formerly 25.5-5-404 (1)(a)]** The MCE shall not interfere with
4 appropriate medical care decisions rendered by ~~the provider nor penalize~~
5 ~~the provider for requesting medical services outside the standard~~
6 ~~treatment protocols developed by the MCE or its contractors.~~ ITS
7 CONTRACTED NETWORK PROVIDERS;

8 (k) THE MCE SHALL COMPLY WITH THE STATE DEPARTMENT'S
9 TRANSITION OF CARE POLICY TO ENSURE CONTINUED ACCESS TO SERVICES
10 DURING A TRANSITION FROM FEE-FOR-SERVICE TO AN MCE OR TRANSITION
11 FROM ONE MCE TO ANOTHER WHEN AN ENROLLEE, IN THE ABSENCE OF
12 CONTINUED ACCESS TO SERVICES, WOULD SUFFER SERIOUS DETRIMENT TO
13 HIS OR HER HEALTH OR BE AT RISK OF HOSPITALIZATION OR
14 INSTITUTIONALIZATION;

15 (l) THE MCE SHALL PROVIDE AND FACILITATE THE DELIVERY OF
16 SERVICES IN A CULTURALLY COMPETENT MANNER TO ALL MEMBERS,
17 INCLUDING THOSE WITH LIMITED ENGLISH PROFICIENCY, DIVERSE
18 CULTURAL AND ETHNIC BACKGROUNDS, AND DISABILITIES, AND
19 REGARDLESS OF GENDER, SEXUAL ORIENTATION, OR GENDER IDENTITY;

20 (m) THE MCE SHALL PROVIDE COMMUNICATIONS IN A MANNER
21 AND FORMAT THAT MAY BE EASILY UNDERSTOOD AND IS READILY
22 ACCESSIBLE BY MEMBERS;

23 (n) **Grievances and appeals.** (I) (A) EACH MCE SHALL
24 ESTABLISH A GRIEVANCE AND APPEAL SYSTEM THAT COMPLIES WITH
25 RULES ESTABLISHED BY THE STATE BOARD AND FEDERAL GOVERNMENT.

26 (B) **[Similar to 25.5-5-406 (1)(b)]** AN ENROLLEE IS ENTITLED TO
27 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 APPEAL ON BEHALF OF THE ENROLLEE. THE PROCEDURE MUST ALLOW FOR THE UNENCUMBERED PARTICIPATION OF PHYSICIANS.

(II) **[Formerly 25.5-5-404 (1)(o)]** The MCE ~~has~~ SHALL HAVE AN established ~~a~~ grievance ~~procedure pursuant to the provisions in section 25.5-5-406 (1)(b)~~ SYSTEM that allows for ~~the~~ CLIENT EXPRESSION OF DISSATISFACTION AT ANY TIME ABOUT ANY MATTER RELATED TO THE MCE'S CONTRACTED SERVICES, OTHER THAN AN ADVERSE BENEFIT DETERMINATION. THE GRIEVANCE SYSTEM MUST PROVIDE timely resolution ~~of disputes regarding the quality of care, services to be provided, and other issues raised by the recipient.~~ OF SUCH matters ~~shall be resolved~~ in a manner consistent with the medical needs of the individual recipient. ~~The MCE shall notify all recipients involved in a dispute with the MCE of their right to seek an administrative review of an adverse decision made by the MCE pursuant to section 25.5-1-107.~~

(III) (A) THE MCE SHALL HAVE AN APPEAL SYSTEM FOR REVIEW OF ANY DETERMINATION BY THE MCE TO DENY A SERVICE AUTHORIZATION REQUEST OR TO AUTHORIZE A SERVICE IN AN AMOUNT, DURATION, OR SCOPE THAT IS LESS THAN REQUESTED.

(B) **[Similar to 25.5-5-406 (1)(b)]** EACH MCE SHALL UTILIZE AN APPEAL PROCESS FOR EXPEDITED REVIEWS THAT COMPLIES WITH RULES ESTABLISHED BY THE STATE BOARD. THE APPEAL PROCESS FOR EXPEDITED REVIEWS MUST 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

1 PROVIDERS.

2 (C) **[Formerly 25.5-5-406 (1)(b)]** ~~Each MCE or PCCM shall~~
3 ~~utilize a complaint and grievance procedure and a process for expedited~~
4 ~~reviews that comply with rules established by the state board. The~~
5 ~~complaint and grievance procedure shall provide a means by which~~
6 ~~enrollees may complain about or grieve any action or failure to act that~~
7 ~~impacts an enrollee's access to, satisfaction with, or the quality of health~~
8 ~~care services, treatments, or providers~~ The state department shall establish
9 the position of ombudsman for medicaid managed care WHO SHALL, IF
10 THE ENROLLEE REQUESTS, ACT AS THE ENROLLEE'S REPRESENTATIVE IN
11 RESOLVING APPEALS WITH THE MCE. It is the intent of the general
12 assembly that the ombudsman for medicaid managed care be independent
13 from the state department and selected through a competitive bidding
14 process. In the event the state department is unable to contract with an
15 independent ombudsman, an employee of the state department may serve
16 as the ombudsman for medicaid managed care. ~~The ombudsman shall, if~~
17 ~~the enrollee requests, act as the enrollee's representative in resolving~~
18 ~~complaints and grievances with the MCE or PCCM. The process for~~
19 ~~expedited reviews shall provide a means by which an enrollee may~~
20 ~~complain and seek resolution concerning any action or failure to act in an~~
21 ~~emergency situation that immediately impacts the enrollee's access to~~
22 ~~quality health care services, treatments, or providers. An enrollee shall be~~
23 ~~entitled to designate a representative, including but not limited to an~~
24 ~~attorney, the ombudsman for medicaid managed care, a lay advocate, or~~
25 ~~the enrollee's physician, to file and pursue a grievance or expedited~~
26 ~~review on behalf of the enrollee. The procedure shall allow for the~~
27 ~~unencumbered participation of physicians.~~ An enrollee whose ~~complaint~~

~~or grievance~~ APPEAL 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~~ SUBSECTION (1)(n), OR WHOSE APPEAL IS DEEMED EXHAUSTED, IS entitled to request a ~~second-level review~~ STATE FAIR HEARING 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.~~

(o) **[Similar to 25.5-5-405]** THE MCE SHALL MAINTAIN AND PARTICIPATE IN AN ONGOING COMPREHENSIVE QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM THAT MUST INCLUDE BUT NOT BE LIMITED TO THE FOLLOWING:

(I) PERFORMANCE IMPROVEMENT PROJECTS DESIGNED TO ACHIEVE SIGNIFICANT IMPROVEMENT, SUSTAINED OVER TIME, IN CLINICAL CARE AND NONCLINICAL CARE AREAS THAT ARE EXPECTED TO HAVE A FAVORABLE EFFECT ON HEALTH OUTCOMES AND MEMBER SATISFACTION;

(II) THE COLLECTION AND SUBMISSION OF PERFORMANCE MEASUREMENT DATA AS REQUIRED BY THE STATE DEPARTMENT;

(III) THE IMPLEMENTATION AND MAINTENANCE OF MECHANISMS TO DETECT OVERUTILIZATION AND UNDERUTILIZATION OF SERVICES AND TO ASSESS THE QUALITY AND APPROPRIATENESS OF CARE FURNISHED TO ITS MEMBERS, INCLUDING MEMBERS WITH SPECIAL HEALTH CARE NEEDS; AND

(IV) THE MCE SHALL PARTICIPATE ANNUALLY IN AN

INDEPENDENT QUALITY REVIEW AND VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS, PERFORMANCE MEASURES, AND OTHER CONTRACT REQUIREMENTS;

(p) THE MCE SHALL ADMINISTER A PROGRAM INTEGRITY SYSTEM TO ENSURE COMPLIANCE WITH ALL REQUIREMENTS ESTABLISHED BY THE FEDERAL GOVERNMENT, STATE OF COLORADO, STATE DEPARTMENT, AND STATE BOARD THAT INCLUDES, BUT IS NOT LIMITED TO:

(I) PROCEDURES TO DETECT AND PREVENT FRAUD, WASTE, AND ABUSE;

(II) SCREENING AND DISCLOSURE PROCESSES TO PREVENT RELATIONSHIPS WITH INDIVIDUALS OR ENTITIES THAT ARE DEBARRED, SUSPENDED, OR OTHERWISE EXCLUDED FROM PARTICIPATING IN ANY FEDERAL HEALTH CARE PROGRAM, PROCUREMENT ACTIVITIES, OR NONPROCUREMENT ACTIVITIES; AND

(III) TREATMENT OF RECOVERIES OF OVERPAYMENT TO PROVIDERS;

(q) **[Formerly 25.5-5-406 (1)(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 PCCM or 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 PCCM;

(r) **[Formerly 25.5-5-406 (1)(d)] Marketing.** In marketing coverage to medicaid recipients, all 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

1 permissible marketing of medicaid managed care. The purposes of such
2 rules ~~shall~~ MUST include but not be limited to the avoidance of biased
3 selection among the choices available to medicaid recipients.
4 (s) **[Formerly 25.5-5-406 (1)(e)] Prescription drugs.** All MCEs
5 that have prescription drugs as a covered benefit shall provide
6 prescription drug coverage in accordance with the provisions of section
7 25.5-5-202 (1)(a) as part of a comprehensive health benefit and with
8 respect to any formulary or other access restrictions:
9 (I) The MCE shall supply participating providers who may
10 prescribe prescription drugs for MCE enrollees with a current copy of
11 such formulary or other access restrictions, including information about
12 coverage, payment, or any requirement for prior authorization; ~~and~~
13 (II) The MCE shall provide to all medicaid recipients at periodic
14 intervals, and prior to and during enrollment upon request, clear and
15 concise information about the prescription drug program in language
16 understandable to the medicaid recipients, including information about
17 such formulary or other access restrictions and procedures for gaining
18 access to prescription drugs, including off-formulary products; AND
19 (III) THE MCE SHALL FOLLOW STATE DEPARTMENT POLICIES FOR
20 PRESCRIBING ANY PRESCRIPTION DRUGS THAT ARE NOT COVERED UNDER
21 THE MCE CONTRACT.
22 **SECTION 4.** In Colorado Revised Statutes, 25.5-5-408, **amend**
23 (1), (6), (7), and (9); and **add with amended and relocated provisions**
24 (13) as follows:
25 **25.5-5-408. Capitation payments - availability of base data -**
26 **adjustments - rate calculation - capitation payment proposal -**
27 **preference - assignment of medicaid recipients - definition.**

1 (1) (a) ~~(I)~~ The state department shall make capitation payments to MCEs
2 based upon a defined scope of services under a risk contract.
3 ~~(II) Repealed.~~
4 (b) A certification by a qualified actuary retained by the state
5 department ~~shall be~~ IS conclusive evidence that the state department has
6 correctly calculated the direct health care cost of providing these same
7 services on an actuarially equivalent Colorado medicaid population
8 group. ~~consisting of unassigned recipients and recipients in the primary~~
9 ~~care physician program provided in section 25.5-5-407.~~
10 (c) Except as otherwise provided in ~~paragraph (d) of this~~
11 ~~subsection (1)~~ SUBSECTION (1)(d) OF THIS SECTION and where the state
12 department has instituted a program of competitive bidding provided in
13 section 25.5-5-402 ~~(3)~~ (9), the state department may utilize a market rate
14 set through the competitive bid process for a set of defined services. The
15 state department shall only use market rate bids that do not discriminate
16 and are adequate to assure quality and network sufficiency. A certification
17 of a qualified actuary, retained by the state department, to the appropriate
18 lower limit ~~shall be~~ IS conclusive evidence of the state department's
19 compliance with the requirements of this ~~paragraph (c)~~ SUBSECTION
20 (1)(c). For the purposes of this subsection (1), a "qualified actuary" ~~shall~~
21 ~~be~~ MEANS a person deemed as such under rules promulgated by the
22 commissioner of insurance.
23 (d) A federally qualified health center, as defined in the federal
24 "Social Security Act", ~~shall~~ MUST be reimbursed by the state department
25 for the total reasonable costs incurred by the center in providing health
26 care services to all recipients of medical assistance.
27 (e) **[Similar to 25.5-5-404 (1)(k)]** AN MCE SHALL CERTIFY, AS A

1 CONDITION OF ENTERING INTO A CONTRACT WITH THE STATE DEPARTMENT,
2 THAT THE CAPITATION PAYMENTS SET FORTH IN THE CONTRACT BETWEEN
3 THE MCE AND THE STATE DEPARTMENT ARE SUFFICIENT TO ENSURE THE
4 FINANCIAL STABILITY OF THE MCE WITH RESPECT TO DELIVERY OF
5 SERVICES TO THE MEDICAID RECIPIENTS COVERED IN THE CONTRACT.

6 (f) (I) **[Formerly 25.5-5-404 (1)(l)]** Except as provided in
7 ~~paragraph (m) of this subsection (1)~~ SUBSECTION (1)(f)(II) OF THIS
8 SECTION, for capitation payments effective on and after July 1, 2003, an
9 MCE that is contracting for a defined scope of services under a risk
10 contract shall certify, through a qualified actuary retained by the MCE,
11 that the capitation payments set forth in the contract between the MCE
12 and the state department comply with all applicable federal and state
13 requirements that govern ~~said~~ THE capitation payments. For purposes of
14 this ~~paragraph (l)~~ SUBSECTION (1)(f)(I), a "qualified actuary" means a
15 person deemed as such by rule promulgated by the commissioner of
16 insurance.

17 (II) **[Formerly 25.5-5-404 (1)(m)]** An MCO providing services
18 under the PACE program as described in section 25.5-5-412 shall certify
19 that the capitation payments are in compliance with applicable federal and
20 state requirements that govern said capitation payments and that the
21 capitation payments are sufficient to ensure the financial viability of the
22 MCO with respect to the delivery of services to the PACE program
23 participants covered in the contract.

24 (6) Within ~~thirty~~ TWO HUNDRED TEN days from the beginning of
25 each fiscal year, the state department, in cooperation with the MCEs, shall
26 set a timeline for the rate-setting process for the following fiscal year's
27 rates and for the provision of base data to the MCEs that is used in the

calculation of the rates, which ~~shall~~ MUST 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 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 MCEs regarding any and all adjustments in the base data made to arrive at the capitation payments.

(9) The rate-setting process referenced in subsection (6) of this section ~~shall~~ MUST include a time period after the 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 MCE to submit to the state department the MCE's capitation payment proposal, which ~~shall~~ MUST 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 MCEs the MCE's specific adjustments to be included in the calculation of the MCE's proposal. Each MCE's capitation payment proposal ~~shall~~ MUST meet the requirements of ~~section 25.5-5-404 (1)(k) and (1)(l)~~ SUBSECTIONS (1)(e) AND (1)(f) OF THIS SECTION AND SECTION 25.5-5-402 (10).

(13) **[Formerly 25.5-5-407.5 (2)(a)]** A PIHP agreement may

include a provision for a quality incentive payment that is distributed to the contractor within a reasonable period of time, as specified in the contract, following the end of each fiscal year if the contractor substantially exceeds predetermined quality indicators. The quality indicators ~~shall~~ MUST 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~~ MUST include, but need not be limited to, the health plan 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~~ MUST 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~~ MUST not exceed five percent of the total medicaid payments received by the contractor during the performance period of the PIHP agreement.

SECTION 5. In Colorado Revised Statutes, 25.5-5-414, **amend** (3), (5), and (6); and **repeal** (4) as follows:

25.5-5-414. Telemedicine - legislative intent. (3) On or after January 1, 2002, face-to-face contact between a health care provider and a patient ~~shall~~ IS not ~~be~~ required under the STATEWIDE managed care system created in this part 4 for services appropriately provided through telemedicine, subject to reimbursement policies developed by the state department to compensate providers who provide health care services covered by the program created in section 25.5-4-104. Telemedicine services may only be used in areas of the state where the technology necessary for the provision of telemedicine exists. The audio and visual

telemedicine system used ~~shall~~ MUST, at a minimum, have the capability to meet the procedural definition of the most recent edition of the current procedural terminology that represents the service provided through telemedicine. The telecommunications equipment ~~shall~~ MUST be of a level of quality to adequately complete all necessary components to document the level of service for the current procedural terminology fourth edition codes that are billed. If a peripheral diagnostic scope is required to assess the patient, it ~~shall~~ MUST provide adequate resolution or audio quality for decision-making.

(4) ~~The state department shall report to the health and human services committees of the house of representatives and the senate, or any successor committees, no later than January 1, 2006, on the application of telemedicine to provide home health care; emergency care; critical and intensive care, including, but not limited to, neonatal care; psychiatric evaluation; psychotherapy; and medical management as potential managed care system benefits. Such report shall take into account the availability of technology as of the time of the report to use telemedicine for home health care, emergency care, and critical and intensive care and the availability of broadband access within the state.~~

(5) The STATEWIDE managed care system ~~shall~~ IS not ~~be~~ required to pay for consultation provided by a provider by telephone or facsimile machines.

(6) The state department may accept and expend gifts, grants, and donations from any source to conduct the valuation of the cost-effectiveness and quality of health care provided through telemedicine by those providers who are reimbursed for telemedicine services by the STATEWIDE managed care system.

1 **SECTION 6.** In Colorado Revised Statutes, 25.5-5-415, **amend**
2 (1)(a)(VI), (1)(b), (2)(b), (2)(c)(II), (2)(c)(III), (2)(d)(I), and (2)(d)(III);
3 and **repeal** (2)(d)(II) as follows:
4 **25.5-5-415. Medicaid payment reform and innovation pilot**
5 **program - legislative declaration - creation - selection of payment**
6 **projects - report - rules.** (1) (a) The general assembly finds that:
7 (VI) The state department shall evaluate how successful payment
8 projects could be replicated and incorporated within the state department's
9 ~~current medicaid coordinated~~ STATEWIDE MANAGED care system.
10 (b) Therefore, the general assembly declares that Colorado should
11 build upon ongoing reforms of health care delivery in the medicaid
12 program by implementing a pilot program within the structure of the state
13 department's ~~current medicaid coordinated~~ STATEWIDE MANAGED care
14 system that encourages the use of new and innovative payment
15 methodologies, including global payments.
16 (2) (b) (I) The state department shall create a process for
17 interested contractors of the state department's ~~current medicaid~~
18 ~~coordinated~~ STATEWIDE MANAGED care system to submit payment
19 projects for consideration under the pilot program. Payment projects
20 submitted pursuant to the pilot program may include, but need not be
21 limited to, global payments, risk adjustment, risk sharing, and aligned
22 payment incentives, including but not limited to gainsharing, to achieve
23 improved quality and to control costs.
24 (II) The design of the payment project or projects ~~shall~~ MUST
25 address the client population of the state department's ~~current medicaid~~
26 ~~coordinated~~ STATEWIDE MANAGED care system and be tailored to the
27 region's health care needs and the resources of the state department's

1 ~~current medicaid coordinated~~ STATEWIDE MANAGED care system.

2 (III) A contractor of the state department's ~~current medicaid~~
3 ~~coordinated~~ STATEWIDE MANAGED care system shall work in coordination
4 with the providers and ~~managed care entities~~ MCEs contracted with the
5 contractor of the state department's ~~current medicaid coordinated~~
6 STATEWIDE MANAGED care system in developing the payment project or
7 projects.

8 (c) (II) For purposes of selecting payment projects for the pilot
9 program, the state department shall consider, at a minimum:

10 (A) The likely effect of the payment project on quality measures,
11 health outcomes, and client satisfaction;

12 (B) The potential of the payment project to reduce the state's
13 medicaid expenditures;

14 (C) **[Similar to 25.5-5-402 (6)(b)(II)]** The state department's
15 ability to ensure that inpatient and outpatient hospital reimbursements are
16 maximized up to the upper payment limits, as defined in 42 CFR 447.272
17 and 42 CFR 447.321 and calculated by the state department periodically;

18 (D) The client population served by the state department's ~~current~~
19 ~~medicaid coordinated~~ STATEWIDE MANAGED care system and the
20 particular health needs of the region;

21 (E) The business structure or structures likely to foster
22 cooperation, coordination, and alignment and the ability of the contractor
23 of the state department's ~~current medicaid coordinated~~ STATEWIDE
24 MANAGED care system to implement the payment project, including the
25 resources available to the contractor of the state department's ~~current~~
26 ~~medicaid coordinated~~ STATEWIDE MANAGED care system and the
27 technological infrastructure required; and

(F) The ability of the contractor of the state department's ~~current medicaid coordinated~~ STATEWIDE MANAGED care system to coordinate among providers of physical health care, behavioral health care, oral health care, and the system of long-term care services and supports.

(III) For payment projects not selected by the state department, the state department shall respond to the contractor of the state department's ~~current medicaid coordinated~~ STATEWIDE MANAGED care system, in writing, stating the reason or reasons why the payment project was not selected. The state department shall send a copy of the response to the joint budget committee of the general assembly, the health and human services committee of the senate, ~~or any successor committee,~~ and the health, INSURANCE, and environment committee of the house of representatives, or any successor ~~committee~~ COMMITTEES.

(d) (I) The payment projects selected for the program ~~shall~~ MUST be for a period of at least one year and ~~shall~~ MUST not extend beyond the length of the contract with the contractor of the state department's ~~current medicaid coordinated~~ STATEWIDE MANAGED care system. The provider contract ~~shall~~ MUST specify the payment methodology utilized in the payment project.

(II) ~~The requirements of section 25.5-5-408 do not apply to the rate-calculation process for payments made to MCEs pursuant to this section.~~

(III) MCEs participating in the pilot program are subject to the requirements of ~~section 25.5-5-404 (1)(k) and (1)(l)~~ SECTIONS 25.5-5-402 (10) AND 25.5-5-408 (1)(e) AND (1)(f), as applicable.

SECTION 7. In Colorado Revised Statutes, **repeal** 25.5-5-404, 25.5-5-405, 25.5-5-406, 25.5-5-407, 25.5-5-407.5, 25.5-5-409,

1 25.5-5-411, 25.5-5-413, and 10-3-903 (2)(k).

2 **SECTION 8.** In Colorado Revised Statutes, 10-16-122, **amend**
3 (1) as follows:

4 **10-16-122. Access to prescription drugs.** (1) Except as provided
5 in section ~~25.5-5-404 (1)(u), C.R.S.~~ 25.5-5-406.1 (1)(s), any pharmacy
6 benefit management firm or intermediary whose contract with a carrier
7 includes an open network shall allow participation by each pharmacy
8 provider in the contract service area. If a pharmacy benefit management
9 firm or intermediary offers an open network, the pharmacy benefit
10 management firm or intermediary may offer such network on a regional
11 or local basis.

12 **SECTION 9.** In Colorado Revised Statutes, 25.5-4-103, **amend**
13 (12) as follows:

14 **25.5-4-103. Definitions.** As used in this article 4 and articles 5
15 and 6 of this title 25.5, unless the context otherwise requires:

16 (12) "Managed care system" means a HEALTH CARE system ~~for~~
17 ~~providing health care services which integrates both the delivery and the~~
18 ~~financing of health care services in an attempt to provide access to~~
19 ~~medical services while containing the cost and use of medical care~~
20 ORGANIZED TO MANAGE COSTS, UTILIZATION, AND QUALITY. THE
21 STATEWIDE MANAGED CARE SYSTEM PROVIDES FOR THE DELIVERY OF
22 HEALTH BENEFITS AND ADDITIONAL SERVICES THROUGH CONTRACTED
23 ARRANGEMENTS BETWEEN STATE MEDICAID AGENCIES AND MCEs.

24 **SECTION 10.** In Colorado Revised Statutes, 25.5-4-401.2,
25 **amend** (1)(d)(II) as follows:

26 **25.5-4-401.2. Performance-based payments - reporting.** (1) To
27 improve health outcomes and lower health care costs, the state department

may develop payments to providers that are based on quantifiable performance or measures of quality of care. These performance-based payments may include, but are not limited to, payments to:

(d) Behavioral health providers, including, but not limited to:

(II) Entities contracted with the STATE department to administer the ~~medicaid community mental health services program,~~ STATEWIDE SYSTEM OF COMMUNITY BEHAVIORAL HEALTH CARE established in section ~~25.5-5-411~~ 25.5-5-402.

SECTION 11. In Colorado Revised Statutes, 27-67-104, **amend** (1)(a) as follows:

27-67-104. Provision of mental health treatment services for youth. (1) (a) A parent or guardian may apply to a mental health agency on behalf of his or her minor child for mental health treatment services for the child pursuant to this section, whether the child is categorically eligible for medicaid under the capitated mental health system described in section ~~25.5-5-411, C.R.S.~~ 25.5-5-402, or whether the parent believes his or her child is a child at risk of out-of-home placement. In such circumstances, it ~~shall be~~ IS the responsibility of the mental health agency to evaluate the child and to clinically assess the child's need for mental health services and, when warranted, to provide treatment services as necessary and in the best interests of the child and the child's family. Subject to available state appropriations, the mental health agency ~~shall be~~ IS responsible for the provision of the treatment services and care management, including any in-home family mental health treatment, other family preservation services, residential treatment, or any post-residential follow-up services that may be appropriate for the child's or family's

1 needs. For the purposes of this section, the term "care management"
2 includes, but is not limited to, consideration of the continuity of care and
3 array of services necessary for appropriately treating the child and the
4 decision-making authority regarding a child's placement in and discharge
5 from mental health services. A dependency or neglect action pursuant to
6 article 3 of title 19 ~~C.R.S., shall~~ IS not ~~be~~ required in order to allow a
7 family access to residential mental health treatment services for a child.
8 **SECTION 12.** In Colorado Revised Statutes, 27-67-105, **amend**
9 (1)(a) introductory portion and (1)(b) as follows:
10 **27-67-105. Monitoring - report.** (1) On or before September 1,
11 2009, and by September 1 of each year thereafter, each community mental
12 health center shall report to the state department the following
13 information, and each behavioral health organization, for those children
14 eligible to receive medicaid benefits whose parent or legal guardian
15 requests residential treatment, shall report to the department of health care
16 policy and financing the following information:
17 (a) The number of children, both those children who are
18 categorically eligible for medicaid under the capitated mental health
19 system described in section ~~25.5-5-411, C.R.S.~~ 25.5-5-402, and those
20 children who are at risk of out-of-home placement, to whom the
21 following services were provided:
22 (b) The number of children, both those children who are
23 categorically eligible for medicaid under the capitated mental health
24 system described in section ~~25.5-5-411, C.R.S.~~ 25.5-5-402, and those
25 children who are at risk of out-of-home placement, referred to the county
26 department for a dependency or neglect investigation pursuant to section
27 27-67-104 (2), and the reasons therefor;

SECTION 13. In Colorado Revised Statutes, **repeal as amended by House Bill 18-1007** 25.5-5-411 (4)(b).

SECTION 14. In Colorado Revised Statutes, 25.5-5-202, **add** (4) as follows:

25.5-5-202. Basic services for the categorically needy - optional services. (4) THE STATE DEPARTMENT AND THE OFFICE OF BEHAVIORAL HEALTH IN THE DEPARTMENT OF HUMAN SERVICES, IN COLLABORATION WITH COMMUNITY MENTAL HEALTH SERVICES PROVIDERS AND SUBSTANCE USE DISORDER PROVIDERS, SHALL ESTABLISH RULES THAT STANDARDIZE UTILIZATION MANAGEMENT AUTHORITY TIMELINES FOR THE NONPHARMACEUTICAL COMPONENTS OF MEDICATION-ASSISTED TREATMENT FOR SUBSTANCE USE DISORDERS.

SECTION 15. Act subject to petition - effective date. (1) Except as provided in subsection (2) of this section, this act takes effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly (August 8, 2018, if adjournment sine die is on May 9, 2018); except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part will not take effect unless approved by the people at the general election to be held in November 2018 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.

(2) Sections 13 and 14 of this act take effect only if House Bill 18-1007 becomes law and take effect either upon the effective date of this act or House Bill 18-1007, whichever is later.