

CHAPTER 228

SOCIAL SERVICES

SENATE BILL 93-122

BY SENATORS Rizzuto and Johnson;
also REPRESENTATIVES Grampas, Berry, and Lawrence.

AN ACT**CONCERNING AMENDMENTS TO THE STATE MEDICAL ASSISTANCE PROGRAM.**

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

SECTION 1. 26-4-103, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

26-4-103. Definitions. As used in this article, unless the context otherwise requires:

(11.5) "OVERPAYMENT" MEANS THE AMOUNT PAID BY AN AGENCY ADMINISTERING THE MEDICAL ASSISTANCE PROGRAM TO A VENDOR PARTICIPATING IN THE PROGRAM, WHICH AMOUNT IS IN EXCESS OF THE AMOUNT THAT IS ALLOWABLE FOR SERVICES FURNISHED AND WHICH IS REQUIRED BY TITLE XIX OF THE FEDERAL "SOCIAL SECURITY ACT" TO BE REFUNDED TO THE APPROPRIATE MEDICAID AGENCIES.

SECTION 2. 26-4-201 (1), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

26-4-201. Mandatory provisions - eligible groups. (1) In order to participate in the medicaid program, the federal government requires the state to provide medical assistance to certain eligible groups. Pursuant to federal law, any person who is eligible for medical assistance under the mandated groups specified in this section shall receive both the mandatory services that are specified in sections 26-4-202 and 26-4-203 and the optional services that are specified in sections 26-4-302 and 26-4-303. Subject to the availability of federal financial aid funds, the following are the individuals or groups which are mandated under federal law to receive benefits

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

under this article:

(m.5) DISABLED WIDOWS OR WIDOWERS FIFTY THROUGH SIXTY YEARS OF AGE WHO HAVE BECOME INELIGIBLE FOR FEDERAL SUPPLEMENTAL SECURITY INCOME OR STATE SUPPLEMENTATION AS A RESULT OF BECOMING ELIGIBLE FOR FEDERAL SOCIAL SECURITY SURVIVOR'S BENEFITS, IN ACCORDANCE WITH THE SOCIAL SECURITY ACT, 42 U.S.C. SEC. 1383c.

SECTION 3. The introductory portion to 26-4-403 (2) and 26-4-403 (2) (b), Colorado Revised Statutes, 1989 Repl. Vol., as amended, are amended to read:

26-4-403. Recoveries - overpayments - penalties - interest - adjustments - liens. (2) Any overpayment to a vendor ~~by the state department, or a recipient due to the vendor's omission, error, fraud, or defalcation,~~ including those of personal needs funds made pursuant to section 26-4-504, shall be recoverable in the following manner:

(b) In order to collect the amounts specified in paragraph (a) of this subsection (2), the state department may withhold subsequent payments to which the vendor is or becomes entitled and apply the amount withheld as an offset. ~~Except where the overpayment resulted from the vendor's fraud, or under terms mutually agreed upon by the state department and the vendor, the amount withheld as an offset shall not exceed twenty-five percent of the payment to which the vendor is entitled.~~ THE STATE BOARD SHALL ESTABLISH IN RULES THE RATE AT WHICH AN OVERPAYMENT MAY BE OFFSET, WITH PROVISION FOR A REDUCTION OF SUCH RATE UPON A GOOD CAUSE SHOWN BY THE VENDOR THAT THE RATE AT WHICH PAYMENT WILL BE WITHHELD WILL RESULT IN AN UNDUE HARDSHIP FOR THE VENDOR. IN DETERMINING WHETHER TO GRANT A GOOD CAUSE REDUCTION, THE STATE DEPARTMENT SHALL CONSIDER THE IMPACT OF COLLECTING THE AMOUNT PROVIDED BY STATE BOARD RULES ON THE QUALITY OF PATIENT CARE AND THE FINANCIAL VIABILITY OF THE PROVIDER. The state department may also take such other steps administratively as are available for the collection of the amounts specified in paragraph (a) of this subsection (2).

SECTION 4. Part 4 of article 4 of title 26, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SECTION to read:

26-4-403.7. Automated medical assistance administration. (1) THE GENERAL ASSEMBLY HEREBY FINDS AND DECLARES THAT THE AGENCY RESPONSIBLE FOR THE ADMINISTRATION OF THE STATE'S MEDICAL ASSISTANCE PROGRAM WOULD BE MORE EFFECTIVE IN ITS ABILITY TO STREAMLINE ADMINISTRATIVE FUNCTIONS OF PROGRAM ADMINISTRATORS AND VENDORS UNDER THE PROGRAM THROUGH THE IMPLEMENTATION OF AN AUTOMATED SYSTEM THAT WILL PROVIDE FOR THE FOLLOWING:

- (a) ELECTRONIC CLAIM SUBMITTALS;
- (b) ON-LINE ELIGIBILITY DETERMINATIONS;
- (c) ELECTRONIC REMITTANCE STATEMENTS;
- (d) ELECTRONIC FUND TRANSFERS; AND

(e) AUTOMATION OF OTHER ADMINISTRATIVE FUNCTIONS ASSOCIATED WITH THE MEDICAL ASSISTANCE PROGRAM.

(2) THEREFORE, THE GENERAL ASSEMBLY DECLARES THAT IT IS APPROPRIATE TO ENACT LEGISLATION, AS SET FORTH IN SUBSECTION (3) OF THIS SECTION, THAT AUTHORIZES THE STATE DEPARTMENT TO DEVELOP AND IMPLEMENT AN AUTOMATED SYSTEM FOR PROCESSING CLAIMS AND PAYMENTS UNDER THE MEDICAL ASSISTANCE PROGRAM, AS WELL AS FOR OTHER ADMINISTRATIVE FUNCTIONS ASSOCIATED WITH THE PROGRAM.

(3) THE EXECUTIVE DIRECTOR OF THE STATE DEPARTMENT SHALL DEVELOP AND IMPLEMENT AN AUTOMATED SYSTEM THROUGH WHICH MEDICAL ASSISTANCE CLAIMS AND PAYMENTS AND ELIGIBILITY DETERMINATIONS OR OTHER RELATED TRANSACTIONS MAY BE PROCESSED. THE SYSTEM SHALL PROVIDE FOR THE USE OF AUTOMATED ELECTRONIC TECHNOLOGIES. THE AUTOMATED SYSTEM MAY BE IMPLEMENTED IN PHASES IF DEEMED NECESSARY BY THE EXECUTIVE DIRECTOR. THE AUTOMATED SYSTEM SHALL BE IMPLEMENTED ONLY AFTER THE EXECUTIVE DIRECTOR DETERMINES THAT:

(a) TECHNOLOGY IS AVAILABLE AND PROVEN TO PERFORM SATISFACTORILY IN A PRODUCTION ENVIRONMENT;

(b) ADEQUATE FINANCING IS AVAILABLE TO FACILITATE THE IMPLEMENTATION AND MAINTENANCE OF THE SYSTEM. FINANCING MAY INCLUDE, BUT IS NOT LIMITED TO, FEDERAL FUNDS, APPROPRIATIONS FROM THE GENERAL FUND, PROVIDER TRANSACTION FEES, OR ANY OTHER FINANCING MECHANISMS WHICH THE STATE DEPARTMENT MAY IMPOSE, AND GRANTS OR CONTRIBUTIONS FROM PUBLIC OR PRIVATE ENTITIES.

(c) THE SYSTEM HAS BEEN SUCCESSFULLY INSTALLED AND FULLY TESTED; AND

(d) ADEQUATE VENDOR TRAINING HAS BEEN PROVIDED FOR AN ORDERLY IMPLEMENTATION.

(4) ON OR BEFORE JULY 1, 1993, AND PRIOR TO THE IMPLEMENTATION OF THE AUTOMATED SYSTEM, THE EXECUTIVE DIRECTOR OF THE STATE DEPARTMENT, WITH INPUT FROM THE PHARMACY ADVISORY COMMITTEE, CREATED IN SECTION 26-4-408, SHALL SUBMIT TO THE STATE MEDICAL ASSISTANCE AND SERVICES ADVISORY COUNCIL CREATED IN SECTION 26-4-108, THE STATE BOARD, AND THE JOINT BUDGET COMMITTEE OF THE GENERAL ASSEMBLY AN IMPLEMENTATION PLAN, ADDRESSING THE ITEMS TO BE DETERMINED IN SUBSECTION (3) OF THIS SECTION.

SECTION 5. 26-4-404 (3) (b) (IV), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

26-4-404. Vendors - payments - rules. (3) (b) (IV) Nothing in this subsection (3) shall apply to any county with a population of twenty thousand or less; EXCEPT THAT A VENDOR MAY PROVIDE CAPITATED SERVICES IN SUCH COUNTIES IF THE VENDOR HAD A CONTRACT TO PROVIDE SUCH SERVICES ON OR BEFORE JULY 1, 1992.

SECTION 6. 26-4-416 (3) (b), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

26-4-416. Vendor assessment plan created - purpose - conditional repeal.

(3) (b) In the event federal financial participation is not available as provided in paragraph (a) of this subsection (3), then any assessments made or credited to the vendor assessment fund for which federal funds are not available shall be returned to the remitting vendor. ANY OVERPAYMENT TO A VENDOR BY THE STATE DEPARTMENT AS A RESULT OF THE DENIAL OF FEDERAL FINANCIAL PARTICIPATION SHALL BE RECOVERABLE BY THE STATE IN THE SAME MANNER AND FOLLOWING THE SAME PROCEDURES AS SPECIFIED IN SECTION 26-4-403 (2).

SECTION 7. 26-4-504 (3) and (4), Colorado Revised Statutes, 1989 Repl. Vol., as amended, are amended to read:

26-4-504. Personal needs funds - amount - patient personal needs trust fund required - funeral and burial expenses - penalty for illegal use. (3) All personal needs funds shall be held in trust by the nursing facility or intermediate care facility for the mentally retarded, or its designated trustee, separate and apart from any other funds of the facility, in a checking account or savings account or any combination thereof established to protect and separate the personal needs funds of the patients. At all times, the principal and all income derived from said principal in the patient personal needs trust fund shall remain the property of the participating patients, and the facility or its designated trustee is bound by all of the duties imposed by law upon fiduciaries in the handling of such fund. The facility or its designated trustee shall post a surety bond in ~~the AN amount of ten thousand dollars to protect~~ ASSURE THE SECURITY OF ALL PERSONAL NEEDS FUNDS DEPOSITED IN the patient personal needs trust fund.

(4) The state department shall establish rules and regulations concerning the establishment of a patient personal needs trust fund and procedures for the maintenance of a system of accounting for expenditures of each patient's personal needs funds. These rules and regulations shall provide that the nursing facility or intermediate care facility for the mentally retarded shall maintain complete records of all receipts and expenditures involving the patient personal needs trust fund, that all expenditures shall be approved by the patient, legal custodian, guardian, or conservator prior to an expenditure, and that each patient or ~~his~~ SUCH PATIENT'S legal custodian, guardian, or conservator shall be given at least a quarterly accounting of the receipts and expenditures of such funds.

SECTION 8. 26-4-504 (2) (b), Colorado Revised Statutes, 1989 Repl. Vol., is RECREATED AND REENACTED, WITH AMENDMENTS, to read:

26-4-504. Personal needs funds - amount - patient personal needs trust fund required - funeral and burial expenses - penalty for illegal use. (2) (b) (I) ON AND AFTER OCTOBER 1, 1992, THE BASIC MAXIMUM AMOUNT PAYABLE PURSUANT TO SUBSECTION (1) OF THIS SECTION FOR PERSONAL NEEDS SHALL BE NINETY DOLLARS FOR THE FOLLOWING PERSONS:

(A) A MEDICAL ASSISTANCE RECIPIENT WHO RECEIVES A NON-SERVICE CONNECTED DISABILITY PENSION FROM THE UNITED STATES VETERANS ADMINISTRATION, HAS NO SPOUSE OR DEPENDENT CHILD, AND IS ADMITTED TO OR IS RESIDING IN A NURSING FACILITY, OTHER THAN FACILITIES DESCRIBED IN SECTION 26-12-401; AND

(B) A MEDICAL ASSISTANCE RECIPIENT WHO IS A SURVIVING SPOUSE OF A PERSON WHO RECEIVED A NON-SERVICE CONNECTED DISABILITY PENSION FROM THE UNITED STATES VETERANS ADMINISTRATION, HAS NO DEPENDENT CHILD, AND IS ADMITTED TO OR IS RESIDING IN A NURSING FACILITY, OTHER THAN FACILITIES DESCRIBED IN SECTION 26-12-401.

(II) THIS PARAGRAPH (b) IS REPEALED, EFFECTIVE SEPTEMBER 30, 1997.

SECTION 9. 26-4-518.5 (1) and (3), Colorado Revised Statutes, 1989 Repl. Vol., as amended, are amended to read:

26-4-518.5. Purchase of health insurance for recipients. (1) The state department shall purchase group health insurance for a medical assistance recipient who is eligible to enroll for such coverage if enrollment of such recipient in the group plan would be cost-effective. IN ADDITION, THE STATE DEPARTMENT MAY PURCHASE INDIVIDUAL HEALTH INSURANCE FOR A MEDICAL ASSISTANCE RECIPIENT WHO IS ELIGIBLE TO ENROLL IN A HEALTH INSURANCE PLAN IF ENROLLMENT OF SUCH RECIPIENT WOULD BE COST-EFFECTIVE TO THIS STATE. A determination of cost-effectiveness shall be in accordance with federal guidelines established by the secretary of the United States department of health and human services.

(3) The state department shall pay any premium, deductible, coinsurance, or other cost-sharing obligation required under the group plan for services covered under the state medical assistance plan. IN ADDITION, THE STATE DEPARTMENT SHALL PAY ANY PREMIUM, DEDUCTIBLE, COINSURANCE, OR OTHER COST-SHARING OBLIGATION REQUIRED UNDER AN INDIVIDUAL PLAN PURCHASED BY THE STATE DEPARTMENT FOR A MEDICAL ASSISTANCE RECIPIENT PURSUANT TO SUBSECTION (1) OF THIS SECTION. Payment of said services shall be treated as payment for medical assistance. Coverage provided by the purchased ~~group~~ health insurance plan shall be considered as third-party liability for the purposes of section 26-4-518.

SECTION 10. 26-4-525 (1) (c) (I), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

26-4-525. Financing of single entry point system. (1) The single entry point system shall be financed with the following moneys:

(c) County contributions, as follows:

(I) The total for the fiscal year beginning July 1, 1990, and for each fiscal year thereafter, which totals shall serve as the base for determining the contribution required in subparagraph (II) of this paragraph (c), of the following: The counties' five percent contribution for home care allowance AND ADULT FOSTER CARE services as required by section 26-1-122.

SECTION 11. 26-4-526 (8), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is repealed as follows:

26-4-526. Purchase access to medicaid program. (8) ~~This section is repealed, effective July 1, 1993.~~

SECTION 12. 26-4-603 (4) and (6), Colorado Revised Statutes, 1989 Repl. Vol., as amended, are amended to read:

26-4-603. Definitions. As used in this subpart 1 and subpart 3 of this part 6, unless the context otherwise requires:

(4) "Alternative care services" means a package of personal care AND homemaker ~~and adult day care~~ services provided in a state-certified alternative care facility.

(6) "Case management services" means ~~services~~ FUNCTIONS performed by a case management agency, including: The assessment of a client's needs, the development and implementation of a case plan for the client, the coordination and monitoring of service delivery, the direct delivery of services as provided by this part 6 or by rules adopted by the state board, the evaluation of service effectiveness, and the reassessment of the client's needs. CASE MANAGEMENT SERVICES SHALL BE REIMBURSED AS AN ADMINISTRATIVE EXPENSE.

SECTION 13. 26-4-607 (1) (c) and (2), Colorado Revised Statutes, 1989 Repl. Vol., as amended, are amended, and the said 26-4-607 is further amended BY THE ADDITION OF A NEW SUBSECTION, to read:

26-4-607. Services for the elderly, blind, and disabled. (1) Subject to the provisions of this subpart 1, home and community-based services for the elderly, blind, and disabled shall include only the following services:

(c) ~~Case management;~~

(2) All providers of home and community-based services for the elderly, blind, and disabled ~~including case management~~, may be separately certified to provide other services, if otherwise qualified.

(3) A CASE MANAGEMENT AGENCY MAY BE CERTIFIED TO PROVIDE THE SERVICES DESCRIBED IN SUBSECTION (1) OF THIS SECTION, IF OTHERWISE QUALIFIED AS A PROVIDER UNDER THE STATE MEDICAL ASSISTANCE PROGRAM.

SECTION 14. 26-4-645 (1) (a), (1) (c), (1) (e), and (3), Colorado Revised Statutes, 1989 Repl. Vol., as amended, are amended to read:

26-4-645. Services for long-term-care eligible persons. (1) Subject to the provisions of this subpart 3, the home and community-based services program for persons with AIDS or ARC shall include the following continuum of long-term care services:

(a) ~~Case management services;~~

(c) ~~Home health services;~~

(e) ~~Hospice services;~~

(3) The provision of the services set forth in subsection (1) of this section shall be subject to the availability of federal matching medicaid funds, pursuant to Title XIX

of the federal "Social Security Act", as amended, for payment of the costs for administration and costs for the provision of such services. CASE MANAGEMENT SERVICES SHALL BE REIMBURSED AS AN ADMINISTRATIVE COST.

SECTION 15. Article 4 of title 26, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW PART to read:

PART 7
ALTERNATIVE PLAN FOR
PROVIDING MEDICAL ASSISTANCE

26-4-701. Legislative declaration. (1) THE GENERAL ASSEMBLY HEREBY FINDS, DETERMINES, AND DECLARES THAT:

(a) COLORADO, LIKE MOST STATES, IS IN A "MEDICAID" CRISIS, DUE SIGNIFICANTLY TO INCREASING MANDATES IMPOSED BY THE FEDERAL GOVERNMENT WITHOUT CORRESPONDING ADJUSTMENTS TO THE FORMULA FOR DETERMINING THE FEDERAL-STATE SHARE IN FINANCING THE MEDICAID PROGRAM;

(b) SUCH FEDERAL MANDATES IN COMBINATION WITH OVERLY BURDENSOME AND COSTLY ADMINISTRATIVE FUNCTIONS ASSOCIATED WITH THE COLORADO MEDICAL ASSISTANCE PROGRAM PRECLUDE THE EXPENDITURE OF MONEYS FOR THE PROVISIONS OF MEDICAL ASSISTANCE TO POOR PERSONS IN THE STATE, MANY OF WHOM ARE CHILDREN;

(c) IF THE TREND OF RAPID ESCALATING COSTS CONTINUES, IT WILL BE IMPOSSIBLE FOR THIS STATE TO CONTINUE TO PARTICIPATE IN THE PROGRAM WITHOUT A DEVASTATING IMPACT ON THE STATE'S BUDGET;

(d) COLORADO HAS AN OPPORTUNITY TO BE IN THE FOREFRONT IN ADOPTING AN INNOVATIVE STATE MEDICAL ASSISTANCE PROGRAM THAT ALLOWS THE STATE TO CONTINUE, IF NOT EXPAND, THE PROVISION OF MEDICAL ASSISTANCE TO ITS IMPOVERISHED CITIZENS, AND TO CONTINUE TO RECEIVE FEDERAL FINANCIAL PARTICIPATION WITHOUT ADHERING TO RESTRICTIVE FEDERAL MANDATES.

(2) THEREFORE, THE GENERAL ASSEMBLY FINDS THAT IT IS APPROPRIATE FOR THE STATE TO STUDY ALTERNATIVE PLANS FOR PROVIDING MEDICAL ASSISTANCE TO ITS POOR AND FOR THE STATE, BASED ON SUCH STUDY, TO ADOPT AN INNOVATIVE STATE MEDICAL ASSISTANCE PROGRAM THAT IS COST-EFFICIENT AND ALLOWS THE STATE TO CONTINUE TO RECEIVE FEDERAL MONEYS, BUT WHICH DOES NOT RESULT IN REDUCING SERVICES OR THE QUALITY OF MEDICAL ASSISTANCE FOR POOR PERSONS IN THIS STATE.

26-4-702. Alternative plan for medical assistance. (1) THE STATE DEPARTMENT SHALL CONTRACT WITH THE EXECUTIVE DIRECTOR OF THE OFFICE OF STATE PLANNING AND BUDGETING, REFERRED TO IN THIS PART 7 AS THE DIRECTOR OF OSPB, TO DEVELOP AN ALTERNATIVE PLAN FOR A NONTRADITIONAL MEDICAL ASSISTANCE PROGRAM FOR THIS STATE. IN DEVELOPING THE PLAN, THE DIRECTOR OF OSPB SHALL CONSULT WITH THE STATE AUDITOR, THE LEGISLATIVE AUDIT COMMITTEE, AND THE STATE DEPARTMENT. THE DIRECTOR OF OSPB SHALL SUBMIT A REPORT ON THE DEVELOPMENT OF THE PLAN FOR REVIEW AND ACTION BY THE GENERAL ASSEMBLY IN ACCORDANCE WITH THIS SUBSECTION (1). THE ALTERNATIVE PLAN SHALL BE A

STATE-STRUCTURED NONTRADITIONAL MEDICAL ASSISTANCE PROGRAM ESTABLISHED UNDER WAIVERS GRANTED BY THE FEDERAL HEALTH CARE FINANCING ADMINISTRATION WHICH IS AN AFFORDABLE COST-CONTAINED PLAN OF CARE FOR AN ELIGIBLE POPULATION. NO LATER THAN DECEMBER 1, 1994, THE DIRECTOR OF OSPB SHALL SUBMIT A PRELIMINARY STATUS REPORT ON THE DEVELOPMENT OF THE ALTERNATIVE PLAN AND A FEDERAL WAIVER PROPOSAL FOR THE IMPLEMENTATION OF SUCH PLAN. SUCH REPORT SHALL BE SUBMITTED TO THE LEGISLATIVE COUNCIL, THE HEALTH, ENVIRONMENT, WELFARE, AND INSTITUTIONS COMMITTEES, AND THE JOINT BUDGET COMMITTEE OF THE GENERAL ASSEMBLY. NO LATER THAN APRIL 1, 1995, A FINAL REPORT ON THE ALTERNATIVE PLAN AND FEDERAL WAIVER PROPOSAL SHALL BE SUBMITTED TO THE GENERAL ASSEMBLY FOR REVIEW AND APPROVAL THROUGH THE ADOPTION OF LEGISLATION. THE REPORT SHALL OUTLINE THE PROVISIONS OF THE ALTERNATIVE PLAN AND SHALL SPECIFY WHAT IMPACT THE ALTERNATIVE PLAN HAS ON ANY ONGOING STUDY IN EFFECT ON SAID DATE, THE OUTCOME OF WHICH STUDY PERTAINS TO THE MEDICAL ASSISTANCE PROGRAM, THE MEDICALLY INDIGENT PROGRAM, OR HEALTH CARE FOR THE CITIZENS OF THIS STATE. SUCH STUDIES INCLUDE, BUT ARE NOT LIMITED TO, A STUDY OF COLORADO CARE, A STUDY OF HEALTH CARE CONDUCTED BY THE GOVERNOR'S COST-CONTAINMENT COUNCIL, STUDIES CONDUCTED BY THE COLORADO HEALTH POLICY COUNCIL, AND STUDIES CONDUCTED BY THE HEALTH DATA COMMISSION. IN ADDITION, THE REPORT SHALL SPECIFY WHAT IMPACT THE ALTERNATIVE PLAN HAS ON ANY STATUTE IN EFFECT ON SAID DATE THAT REFORMS THE METHODS FOR PROVIDING MEDICAL ASSISTANCE TO THE POOR OF THIS STATE OR HEALTH CARE TO CITIZENS IN THIS STATE. UPON THE PASSAGE OF LEGISLATION APPROVING THE ALTERNATIVE PLAN AND THE WAIVER PROPOSAL, BUT NO LATER THAN JULY 1, 1996, THE STATE DEPARTMENT AND THE DIRECTOR OF OSPB SHALL SUBMIT THE WAIVER PROPOSAL TO THE FEDERAL HEALTH CARE FINANCING ADMINISTRATION. THE FINAL REPORT SHALL INCLUDE A PRELIMINARY ASSESSMENT OF THE IMPACT OF A STATE MEDICAL ASSISTANCE PROGRAM OPERATED SOLELY WITH STATE FUNDS. THE STUDY AND DEVELOPMENT OF SUCH A PROGRAM SHALL CONTINUE DURING THE PERIOD IN WHICH THE GENERAL ASSEMBLY CONSIDERS THE ALTERNATIVE PLAN FOR A NONTRADITIONAL MEDICAL ASSISTANCE PROGRAM IN ACCORDANCE WITH THE PROVISIONS OF THIS SECTION.

(2) PRIOR TO JULY 1, 1996, THE GENERAL ASSEMBLY SHALL CONSIDER LEGISLATION TO ADOPT AN ALTERNATIVE PROGRAM FOR PROVIDING MEDICAL ASSISTANCE TO POOR PERSONS IN THIS STATE. IT IS THE INTENT OF THE GENERAL ASSEMBLY THAT SUCH PROGRAM ALLOW THE STATE AS MUCH SELF-DIRECTION AND OVERSIGHT OF THE PROGRAM AS POSSIBLE. THE GENERAL ASSEMBLY MAY ADOPT THE PLAN DESCRIBED IN SUBSECTION (1) OF THIS SECTION AS SUBMITTED BY THE DIRECTOR OF OSPB OR MAY ADOPT ANY OTHER ALTERNATIVE PLAN THAT IS DESIGNED TO REDUCE THE COST TO THE STATE OF PARTICIPATING IN THE FEDERAL "MEDICAID PROGRAM". IN THE EVENT THE GENERAL ASSEMBLY ADOPTS A PLAN OTHER THAN THE PLAN FOR WHICH THE STATE DEPARTMENT AND THE DIRECTOR OF OSPB HAVE SUBMITTED A WAIVER, THE STATE DEPARTMENT AND THE DIRECTOR OF OSPB SHALL AMEND THE WAIVER PROPOSAL TO CONFORM WITH THE PLAN ADOPTED BY THE GENERAL ASSEMBLY.

(3) THE DIRECTOR OF OSPB SHALL, IN DEVELOPING ANY PLAN OR WAIVER PROPOSAL DESCRIBED IN THIS SECTION, REPORT ON A REGULAR BASIS TO THE MEMBERS OF THE JOINT BUDGET COMMITTEE, THE LEGISLATIVE COUNCIL, AND THE HEALTH, ENVIRONMENT, WELFARE, AND INSTITUTIONS COMMITTEES OF THE GENERAL

ASSEMBLY.

(4) THE STATE DEPARTMENT SHALL COOPERATE WITH THE DIRECTOR OF OSPB IN THE DEVELOPMENT OF THE ALTERNATIVE PLAN IN ACCORDANCE WITH THIS SECTION.

(5) THE EXECUTIVE DIRECTOR OF THE STATE DEPARTMENT IS HEREBY AUTHORIZED TO ACCEPT ON BEHALF OF THE STATE ANY GRANTS OR DONATIONS FROM ANY PRIVATE SOURCE AND ANY PUBLIC MONEYS APPROPRIATED FOR THE PURPOSE OF IMPLEMENTING THIS SECTION.

26-4-703. Cost-containment and utilization control plan. (1) THE STATE DEPARTMENT, UPON A DETERMINATION OF FEASIBILITY AND THE PROJECTED COST-SAVINGS BY THE EXECUTIVE DIRECTOR OF SAID DEPARTMENT, IS HEREBY AUTHORIZED TO DEVELOP WRITTEN IMPLEMENTATION PLANS FOR THE FOLLOWING COST-CONTAINMENT AND UTILIZATION CONTROL MEASURES:

(a) THE REALLOCATION OF MEDICALLY INDIGENT PROGRAM MONEYS TO THE MEDICAL ASSISTANCE PROGRAM FOR THE PURPOSE OF INCREASING FEDERAL FINANCIAL PARTICIPATION, THEREBY INCREASING THE AMOUNT OF FUNDS AVAILABLE FOR HEALTH CARE FOR LOW-INCOME PEOPLE IN THIS STATE;

(b) AN ADJUSTMENT TO THE COPAYMENTS FOR HEALTH CARE SERVICES, WHICH COPAYMENTS ARE REQUIRED OF MEDICAL ASSISTANCE RECIPIENTS. SUCH ADJUSTMENT MAY INCLUDE THE IMPOSITION OF A COPAYMENT FROM RECIPIENTS EXEMPTED BY FEDERAL REGULATIONS.

(c) THE IMPOSITION OF SERVICE LIMITS ON SPECIFIC MEDICAL AND HEALTH CARE SERVICES;

(d) (I) COMPETITIVE PROCUREMENT AND CONTRACTING FOR HEALTH CARE SERVICES. HOWEVER, FACTORS CONCERNING THE SELECTION OF ENTITIES AND METHODS TO DELIVER HEALTH CARE PURSUANT TO THIS ARTICLE SHALL BE ASSESSED AND SUCH ASSESSMENT SHALL BE SPECIFICALLY ADDRESSED IN THE STATE'S IMPLEMENTATION PLANS. THE FACTORS TO BE ASSESSED SHALL INCLUDE, BUT ARE NOT LIMITED TO, ALL OF THE FOLLOWING:

(A) ACCESS TO NECESSARY QUALITY MEDICAL SERVICES WITHIN OR NEAR COMMUNITIES IN WHICH MEDICAL ASSISTANCE RECIPIENTS AND THEIR FAMILIES RESIDE;

(B) SPECIAL NEEDS OF CLIENT POPULATIONS WITHIN THE COMMUNITIES, INCLUDING BUT NOT LIMITED TO, DEVELOPMENTAL, PHYSICAL, MENTAL, CULTURAL, AND LANGUAGE NEEDS;

(C) ECONOMIC IMPACT UPON COMMUNITIES BASED ON INFORMATION WHICH SHALL BE OBTAINED FROM THE OFFICE OF STATE PLANNING AND BUDGETING;

(D) PRESCRIBING PRACTICES;

(E) DISCRIMINATORY PRICING OF GOODS AND SERVICES;

(F) DRUG UTILIZATION REVIEW;

(G) COST-SAVINGS DERIVED FROM ELECTRONIC MANAGED CARE, CONSIDERING APPROPRIATE IMPLEMENTATION SEQUENCING ISSUES;

(H) IMPACT ON RESIDENCY TRAINING PROGRAMS;

(I) THE LIVING SITUATION OF MEDICAL ASSISTANCE RECIPIENTS WHO RECEIVE SERVICE IN RESIDENTIAL OR HEALTH CARE FACILITY SETTINGS WITH CONSIDERATION OF THE IMPACT THAT POTENTIAL INVOLUNTARY TRANSFERS OR ADVERSE ACTIONS MAY HAVE ON A PATIENT'S HEALTH OR PSYCHO-SOCIAL WELL-BEING;

(J) THE FEASIBILITY OF ALLOWING ANY VENDOR THAT CAN MEET THE RATE AND SERVICE STANDARDS ESTABLISHED IN THE BIDDING PROCESS TO CONTRACT AND DELIVER HEALTH CARE SERVICES.

(II) MEDICAID PATIENTS WHO HAVE RESIDED IN A PARTICULAR RESIDENTIAL FACILITY FOR ONE YEAR OR LONGER WILL NOT BE INVOLUNTARILY TRANSFERRED TO OTHER FACILITIES SOLELY AS A RESULT OF THE STATE'S IMPLEMENTATION OF A COMPETITIVE BIDDING OR SELECTIVE CONTRACTING PROCESS.

(e) THE REQUIREMENT THAT REIMBURSEMENT CLAIMS BY VENDORS BE RECEIVED BY THE FISCAL AGENT FOR THE STATE DEPARTMENT WITHIN ONE HUNDRED TWENTY DAYS AFTER THE DATE ON WHICH ANY IN-PATIENT HOSPITAL, HOME HEALTH, HOSPICE, OR HOME AND COMMUNITY-BASED SERVICES, INCLUDING SERVICES FOR THE ELDERLY, BLIND, AND DISABLED, SERVICES FOR THE DEVELOPMENTALLY DISABLED, AND SERVICES FOR PERSONS LIVING WITH AIDS, ARE RENDERED OR AFTER THE MEDICARE PROCESSING DATE FOR ANY MEDICARE CROSSOVER CLAIM AND WITHIN ONE HUNDRED TWENTY DAYS AFTER THE DATE OF SERVICE FOR ANY OTHER HEALTH CARE SERVICE. SUCH MEASURE SHALL PROVIDE FOR THE DENIAL OF PAYMENT FOR ANY LATE SUBMITTAL, UNLESS SUCH SUBMITTAL WAS BEYOND THE VENDOR'S CONTROL. THE PROVISION IN THIS PARAGRAPH (e) SHALL BE IMPLEMENTED ONLY UPON A DETERMINATION BY THE EXECUTIVE DIRECTOR THAT ADEQUATE MECHANISMS ARE IN PLACE TO ASSURE THAT CLAIMS ARE NOT FOUND TO BE OUT OF TIMELY FILING DUE TO DELAYS IN ELIGIBILITY DETERMINATION BEYOND THE CONTROL OF HEALTH CARE PROVIDERS.

(2) THE EXECUTIVE DIRECTOR OF THE STATE DEPARTMENT, IN DEVELOPING COST-CONTAINMENT AND UTILIZATION CONTROL MEASURES, SHALL, ON A REGULAR BASIS, CONSULT FULLY WITH THE MEMBERS OF THE STATE MEDICAL ASSISTANCE AND SERVICES ADVISORY COUNCIL CREATED IN SECTION 26-4-108, REPRESENTATIVES OF AFFECTED PROVIDER AND CLIENT ORGANIZATIONS THROUGHOUT THE STATE, MEMBERS OF THE JOINT BUDGET COMMITTEE AND THE HEALTH, ENVIRONMENT, WELFARE, AND INSTITUTIONS COMMITTEES OF THE GENERAL ASSEMBLY, AND THE STATE BOARD OF SOCIAL SERVICES.

(3) ON OR BEFORE DECEMBER 31, 1993, THE STATE DEPARTMENT SHALL SEEK ANY WAIVER NECESSARY FOR THE IMPLEMENTATION OF THE COST-CONTAINMENT AND UTILIZATION CONTROL MEASURES DESCRIBED IN PARAGRAPHS (a) TO (e) OF SUBSECTION (1) OF THIS SECTION.

(4) UPON RECEIPT OF NECESSARY FEDERAL WAIVERS FOR COST-CONTAINMENT AND UTILIZATION CONTROL MEASURES AND UPON REVIEW AND APPROVAL OF THE GENERAL ASSEMBLY THROUGH THE ADOPTION OF AUTHORIZING LEGISLATION, THE STATE DEPARTMENT SHALL ADOPT RULES NECESSARY FOR THE IMPLEMENTATION OF MEASURES APPROVED BY THE GENERAL ASSEMBLY AND, IF APPLICABLE, AUTHORIZED BY A FEDERAL WAIVER. PRIOR TO OBTAINING APPROVAL BY THE GENERAL ASSEMBLY, THE STATE DEPARTMENT'S PLANS TO IMPLEMENT COST-CONTAINMENT AND UTILIZATION CONTROL MEASURES SHALL BE REVIEWED BY REPRESENTATIVES OF AFFECTED PROVIDER AND CLIENT ORGANIZATIONS THROUGHOUT THE STATE.

26-4-704. Medical assistance reform advisory committee. (1) IN ORDER FOR THE AGENCY RESPONSIBLE FOR DEVELOPING AN ALTERNATIVE PLAN FOR A NONTRADITIONAL MEDICAL ASSISTANCE PROGRAM FOR THE STATE, IN ACCORDANCE WITH SECTION 26-4-702, TO OBTAIN SUFFICIENT INPUT IN DEVELOPING SUCH PLAN, THERE IS HEREBY ESTABLISHED A MEDICAL ASSISTANCE REFORM ADVISORY COMMITTEE. THE MEMBERSHIP OF THE COMMITTEE SHALL CONSIST OF FOURTEEN MEMBERS WHO SHALL BE SELECTED AS FOLLOWS:

(a) THE SPEAKER AND THE MINORITY LEADER OF THE HOUSE OF REPRESENTATIVES AND THE PRESIDENT AND MINORITY LEADER OF THE SENATE SHALL EACH APPOINT ONE LEGISLATIVE MEMBER TO SERVE ON THE COMMITTEE AND SHALL JOINTLY APPOINT ONE OF THOSE MEMBERS TO SERVE AS THE CHAIR OF THE COMMITTEE;

(b) THE SPEAKER OF THE HOUSE OF REPRESENTATIVES AND THE PRESIDENT OF THE SENATE SHALL JOINTLY APPOINT THREE MEMBERS EACH OF WHOM SHALL RESPECTIVELY REPRESENT VENDORS WHO PARTICIPATE IN THE MEDICAL ASSISTANCE PROGRAM, CONSUMERS UNDER THE MEDICAL ASSISTANCE PROGRAM OR CONSUMER ADVOCATES THEREFOR, AND MEMBERS OF THE GENERAL PUBLIC;

(c) THE GOVERNOR SHALL APPOINT SEVEN MEMBERS, WHO SHALL BE SELECTED FROM AMONG REPRESENTATIVES OF THE GROUPS DESCRIBED IN PARAGRAPH (b) OF THIS SUBSECTION (1).

(2) APPOINTMENTS TO THE COMMITTEE SHALL BE MADE NO LATER THAN JANUARY 1, 1994. THE MEMBERS OF THE COMMITTEE SHALL SERVE WITHOUT COMPENSATION.

(3) THE ADVISORY COMMITTEE SHALL MEET WITH THE AGENCY RESPONSIBLE FOR DEVELOPING THE ALTERNATIVE PLAN IN ACCORDANCE WITH SECTION 26-4-702 ON A MONTHLY BASIS TO REVIEW AND PROVIDE INPUT ON THE DEVELOPMENT OF SUCH PLAN.

SECTION 16. Appropriation in 1993 long bill to be adjusted. For the implementation of this act, the appropriation made in the annual general appropriation act for the fiscal year beginning July 1, 1993, to the department of social services for medical programs, shall be adjusted as follows: The federal fund appropriation is decreased by fifty-six thousand three hundred seventy-one dollars (\$56,371), and the general fund appropriation is increased by fifty-six thousand three hundred seventy-one dollars (\$56,371) and shall be subject to the "(M)" notation as defined in the general appropriation act.

SECTION 17. 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: June 3, 1993