CHAPTER 241

HUMAN SERVICES - SOCIAL SERVICES

SENATE BILL 97-005

BY SENATORS Hopper, Bishop, Hernandez, Johnson, Matsunaka, Norton, Reeves, Rizzuto, Weddig, and Wham;
also REPRESENTATIVES Owen, Clarke, Dyer, Grampsas, Hagedorn, Keller, Lawrence, Leyba, and Saliman.

AN ACT

CONCERNING MEDICAID MANAGED CARE, AND MAKING AN APPROPRIATION IN CONNECTION THEREWITH.

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

SECTION 1. Part 1 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:

26-4-101.5. Short title - citation. THIS SUBPART 1 CONSISTS OF SECTIONS 26-4-101 TO 26-4-110 AND MAY BE CITED AS SUBPART 1. THE TITLE OF THIS SUBPART 1 SHALL BE KNOWN AND MAY BE CITED AS "GENERAL PROVISIONS".

SECTION 2. 26-4-104, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

26-4-104. Program of medical assistance - single state agency. ~~(1)~~ The state department, by rules and regulations, shall establish a program of medical assistance to provide necessary medical care for the categorically needy. The state department is hereby designated as the single state agency to administer such program in accordance with Title XIX and this article. Such program shall not be required to furnish recipients under sixty-five years of age the benefits that are provided to recipients sixty-five years of age and over under Title XVIII of the social security act; but said program shall otherwise be uniform to the extent required by Title XIX of the social security act.

~~(2) The state department shall promulgate rules and regulations which establish a managed care system for the provision of medical services under this article. Said~~

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

~~rules may include, but are not limited to, the establishment of programs which require the selection of one physician or organization to provide primary care and consultation to a recipient of assistance under this article, standards for selection of a primary care provider, utilization review and quality assurance programs, and financial incentives for the operation of a program.~~

SECTION 3. Part 1 of article 4 of title 26, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SUBPART CONTAINING RELOCATED PROVISIONS, WITH AMENDMENTS, to read:

SUBPART 2
STATEWIDE MANAGED CARE SYSTEM

26-4-111. Short title - citation. THIS SUBPART 2 CONSISTS OF SECTIONS 26-4-111 TO 26-4-130 AND MAY BE CITED AS SUBPART 2. THE TITLE OF THIS SUBPART 2 SHALL BE KNOWN AND MAY BE CITED AS THE "STATEWIDE MANAGED CARE SYSTEM".

26-4-112. Legislative declaration. (1) THE GENERAL ASSEMBLY HEREBY FINDS THAT:

(a) COLORADO'S BUDGET, LIKE THE BUDGETS OF MANY STATES, HAS BEEN CONSTRAINED BY THE INCREASING COSTS ASSOCIATED WITH FEDERAL PROGRAMS. FEDERAL MANDATES CAUSE STATE BUDGETARY STRAIN WHEN IMPOSED WITHOUT CORRESPONDING ADJUSTMENTS TO THE FINANCING FORMULA FOR DETERMINING THE FEDERAL-STATE SHARE. THIS PHENOMENON HAS BEEN PARTICULARLY EVIDENT IN THE IMPLEMENTATION OF THE FEDERAL MEDICAID PROGRAM.

(b) THE FEDERAL MEDICAID PROGRAM DOES NOT ADEQUATELY ADDRESS THE NEEDS OF ALL IMPOVERISHED COLORADO CITIZENS AND, AS A RESULT, THIS STATE FINDS IT NECESSARY TO ADDRESS THE MEDICAL NEEDS OF ITS POOR THROUGH STATE-FUNDED PROGRAMS, INCLUDING BUT NOT LIMITED TO THE "CHILDREN'S HEALTH PLAN ACT", ARTICLE 17 OF THIS TITLE, AND THE "REFORM ACT FOR THE PROVISION OF HEALTH CARE FOR THE MEDICALLY INDIGENT", ARTICLE 15 OF THIS TITLE;

(c) (I) THE FEDERAL GOVERNMENT MAY CHOOSE TO PROVIDE FUNDING FOR MEDICAL ASSISTANCE PROGRAMS THROUGH FEDERAL BLOCK GRANTS. IF STATES ARE GIVEN MAXIMUM FLEXIBILITY FOR THE IMPLEMENTATION OF MEDICAL ASSISTANCE PROGRAMS USING THE BLOCK GRANTS, THIS STATE MAY BE IN A POSITION TO BALANCE THE STATE'S TOTAL BUDGETARY NEEDS WITH THE NEEDS OF THE STATE'S POOR WITHOUT ADHERENCE TO RESTRICTIVE FEDERAL REQUIREMENTS THAT MAY BE IMPRACTICAL FOR COLORADO.

(II) IF THE FEDERAL GOVERNMENT REDUCES ITS FEDERAL FINANCIAL PARTICIPATION WITHOUT MAKING ANY CORRESPONDING CHANGES TO FEDERAL REQUIREMENTS, THIS STATE WILL NEED TO DETERMINE WHICH POPULATIONS CAN BE SERVED IN THE MOST COST-EFFICIENT MANNER;

(d) WHETHER THE FEDERAL GOVERNMENT FUNDS MEDICAL ASSISTANCE PROGRAMS THROUGH BLOCK GRANTS OR REDUCES ITS FINANCIAL PARTICIPATION WITHOUT CHANGING ANY FEDERAL REQUIREMENTS, COLORADO HAS AN OPPORTUNITY TO ADOPT

INNOVATIVE AND COST-EFFICIENT STATE MEDICAL ASSISTANCE STRATEGIES FOR MEETING THE MEDICAL NEEDS OF ITS IMPOVERISHED CITIZENS;

(e) THE EXPERIENCE OF OTHER STATES INDICATES THAT REACTIVE, RAPID, AND COMPREHENSIVE CHANGES TO A STATE'S MEDICAL ASSISTANCE PROGRAM CAN BE COSTLY AND INEFFICIENT;

(f) COLORADO HAS ADOPTED MANAGED CARE ON A SMALL SCALE BASIS FOR SPECIFIC POPULATIONS AND IS CONDUCTING PILOT PROGRAMS FOR OTHER POPULATIONS, INCLUDING BUT NOT LIMITED TO MANAGED CARE, CAPITATED MANAGED CARE, THE USE OF PRIMARY CARE PHYSICIANS, COPAYMENTS, AND MANAGED CARE PROGRAMS FOR THE ELDERLY SUCH AS THE PACE PROGRAM;

(g) IT IS IN THE STATE'S BEST INTEREST TO ENSURE THAT ALL MEDICAL ASSISTANCE PROGRAMS PROMOTE INDEPENDENT LIVING AND THAT ALL REGULATIONS FOR SUCH PROGRAMS ARE DEVELOPED WITH MAXIMUM RECIPIENT INVOLVEMENT; AND

(h) TO THE EXTENT IT IS NECESSARY FOR THE STATE DEPARTMENT TO ASSIGN A RECIPIENT TO A MANAGED CARE PROVIDER, THE STATE DEPARTMENT SHALL TO THE EXTENT POSSIBLE CONSIDER THE CONTINUUM OF THE RECIPIENT'S CARE.

(2) THE GENERAL ASSEMBLY FURTHER FINDS THAT, WITH RECOMMENDATIONS FROM THE MEDICAL ASSISTANCE REFORM ADVISORY COMMITTEE CREATED IN SECTION 26-4-704, THE OFFICE OF STATE PLANNING AND BUDGETING HAS STUDIED THE ALTERNATIVE METHODS OF PROVIDING MEDICAL ASSISTANCE TAKING INTO ACCOUNT COST-EFFICIENCY, CONTINUED RECEIPT OF FEDERAL MONEYS, AND MINIMAL IMPACT ON THE QUALITY OF MEDICAL ASSISTANCE FOR POOR PERSONS IN THIS STATE.

(3) (a) THE GENERAL ASSEMBLY DECLARES THAT IT IS IN THE STATE'S BEST INTEREST TO USE SAVINGS IN MEDICAID PER CAPITA COSTS FROM THE IMPLEMENTATION OF THIS SUBPART 2 AND FROM THE IMPLEMENTATION OF SECTION 26-4-404 (1) (b) TO COVER THE ADMINISTRATIVE COSTS OF IMPLEMENTING MANAGED CARE PURSUANT TO THE PROVISIONS OF THIS SUBPART 2.

(b) REMAINING SAVINGS IN MEDICAID PER CAPITA COSTS FROM THE IMPLEMENTATION OF THIS SUBPART 2 SHALL BE USED TO ESTABLISH PROGRAMS TO INSURE ADDITIONAL LOW-INCOME COLORADANS AND TO SUPPORT ESSENTIAL COMMUNITY PROVIDERS AS LONG AS SUCH NEW PROGRAMS DO NOT CREATE AN ENTITLEMENT TO SERVICES AND MINIMIZE ANY SUBSTITUTION OF SUBSIDIZED COVERAGE FOR EMPLOYER-BASED COVERAGE.

(c) REMAINING SAVINGS IN MEDICAID PER CAPITA COSTS FROM THE IMPLEMENTATION OF SECTION 26-4-404 (1) (b) MAY BE USED FOR THE EXPANSION OF THE INCENTIVE PROGRAM TO PROVIDERS OF DENTAL SERVICES FOR CHILDREN UNDER THE EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT PROGRAM.

(4) THE GENERAL ASSEMBLY THEREFORE DECLARES THAT IT IS IN THE STATE'S BEST INTEREST TO ADOPT THIS SUBPART 2.

26-4-113. Statewide managed care system - implementation required. (1) **Rules.** (a) EXCEPT AS PROVIDED IN SUBSECTION (5) OF THIS SECTION, THE STATE

DEPARTMENT SHALL ADOPT RULES TO IMPLEMENT A MANAGED CARE SYSTEM FOR SEVENTY-FIVE PERCENT OF THE COLORADO MEDICAL ASSISTANCE POPULATION ON A STATEWIDE BASIS PURSUANT TO THE PROVISIONS OF THIS ARTICLE. THE MANAGED CARE SYSTEM IMPLEMENTED PURSUANT TO THIS ARTICLE SHALL NOT INCLUDE THE SERVICES DELIVERED UNDER THE RESIDENTIAL CHILD HEALTH CARE PROGRAM DESCRIBED IN SECTION 26-4-527. THE RULES SHALL INCLUDE A PLAN TO IMPLEMENT THE STATEWIDE MANAGED CARE SYSTEM OVER A THREE-YEAR PERIOD PURSUANT TO THE PROVISIONS OF SUBSECTION (2) OF THIS SECTION.

(b) IT IS THE GENERAL ASSEMBLY'S INTENT THAT THE STATE DEPARTMENT ELIMINATE ADMINISTRATIVE RULES AND FUNCTIONS THAT ARE UNNECESSARY AND UNRELATED TO THE IMPLEMENTATION OF THE STATEWIDE MANAGED CARE SYSTEM. THE RULES AND FUNCTIONS SHALL BE REDUCED ACCORDING TO THE SCHEDULE FOR IMPLEMENTING THE STATEWIDE MANAGED CARE SYSTEM IN SUBSECTION (2) OF THIS SECTION. THE STATE DEPARTMENT SHALL TAKE INTO CONSIDERATION RECOMMENDATIONS FROM MANAGED CARE PROVIDERS, RECIPIENTS OR THEIR ADVOCATES, HEALTH CARE COVERAGE COOPERATIVES, AND THE MEDICAL ASSISTANCE REFORM ADVISORY COMMITTEE IN ELIMINATING UNNECESSARY AND UNRELATED RULES AND FUNCTIONS.

(2) **Statewide managed care - implementation.** (a) SUBJECT TO THE PROVISIONS OF SUBSECTION (5) OF THIS SECTION AND SECTION 26-4-121 (2), IF THE EXECUTIVE DIRECTOR DETERMINES THAT THEY HAVE BEEN EFFECTIVE, ALL MANAGED CARE CONTRACTS AND PILOT PROJECTS IN EFFECT OR WITH APPROVED FEDERAL WAIVERS AS OF JULY 1, 1997, MAY BE IMPLEMENTED ON A STATEWIDE BASIS NO LATER THAN JULY 1, 2000, UNLESS OTHERWISE REPEALED BY THE GENERAL ASSEMBLY BEFORE THAT DATE.

(b) MANAGED CARE PILOT PROJECTS THAT SHALL BE IN EFFECT OR AUTHORIZED AS OF JULY 1, 1997, ARE THE FOLLOWING:

(I) **Acute and long-term care.** THE INTEGRATED CARE AND FINANCING PROJECT TO STUDY THE INTEGRATION OF ACUTE AND LONG-TERM CARE, AS DESCRIBED IN SECTION 26-4-122;

(II) **Managed care contracts.** LIMITED ENROLLMENT IN CAPITATED MANAGED CARE FOR MEDICAL ASSISTANCE RECIPIENTS.

(III) **Mental health.** MANAGED MENTAL HEALTH SERVICES, AS DESCRIBED IN SECTION 26-4-123 [FORMERLY 26-4-528];

(IV) **Elderly.** PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY, AS DESCRIBED IN SECTION 26-4-124 [FORMERLY 26-4-519];

(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 PROVIDING MEDICAL SERVICES ON A MANAGED CARE BASIS FOR PERSONS 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 26-4-115 AND 26-4-117.

(4) **Waivers.** THE IMPLEMENTATION OF THIS SUBPART 2 IS CONDITIONED, TO THE EXTENT APPLICABLE, ON THE ISSUANCE OF NECESSARY WAIVERS BY THE FEDERAL GOVERNMENT. THE PROVISIONS OF THIS SUBPART 2 SHALL BE IMPLEMENTED TO THE EXTENT AUTHORIZED BY FEDERAL WAIVER, IF SO REQUIRED BY FEDERAL LAW.

(5) **Long-term care assessment.** (a) WITH THE EXCEPTION OF THE PILOT PROGRAMS DESCRIBED IN SUBSECTION (2) OF THIS SECTION, THE STATE DEPARTMENT SHALL NOT CONTRACT FOR LONG-TERM CARE SERVICES AS PART OF THE STATEWIDE MANAGED CARE SYSTEM UNTIL FURTHER AUTHORIZATION BY THE JOINT BUDGET COMMITTEE, THE COMMITTEE ON HEALTH, ENVIRONMENT, WELFARE, AND INSTITUTIONS IN THE SENATE, AND THE COMMITTEE ON HEALTH, ENVIRONMENT, WELFARE, AND INSTITUTIONS IN THE HOUSE OF REPRESENTATIVES FOLLOWING THE STATE DEPARTMENT'S ASSESSMENT REQUIRED BY PARAGRAPH (b) OF THIS SUBSECTION (5). FOR PURPOSES OF THIS SUBSECTION (5), "LONG-TERM CARE SERVICES" MEANS NURSING FACILITY AND HOME AND COMMUNITY-BASED SERVICES PROVIDED TO ELIGIBLE RECIPIENTS WHO HAVE BEEN DETERMINED TO BE IN NEED OF SUCH SERVICES BY A SINGLE ENTRY POINT AGENCY OR PROFESSIONAL REVIEW ORGANIZATION AS REQUIRED BY TITLE XIX OF THE SOCIAL SECURITY ACT.

(b) DURING THE THREE-YEAR PERIOD FOR IMPLEMENTATION OF STATEWIDE MANAGED CARE PURSUANT TO SUBSECTION (2) OF THIS SECTION, THE STATE DEPARTMENT SHALL ASSESS THE RESULTS OF THE INTEGRATED CARE AND FINANCING PROJECT DESCRIBED IN SECTION 26-4-122, THE PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY DESCRIBED IN SECTION 26-4-124, AND, IF SENATE BILL 97-42 BECOMES LAW, THE SYSTEM OF CASE-MIX REIMBURSEMENT FOR NURSING FACILITIES, INCLUDING PAYMENT FOR ANCILLARY SERVICES SUCH AS PHARMACEUTICAL SERVICES, PRESCRIPTION DRUGS, AND OXYGEN AS PART OF THAT SYSTEM. THE STATE DEPARTMENT'S ASSESSMENT SHALL INCLUDE CONSIDERATION OF COMMENTS AND INPUT FROM LONG-TERM CARE PROVIDERS, RECIPIENTS OR THEIR ADVOCATES, AND FAMILIES. THE STATE DEPARTMENT SHALL INCLUDE IN ITS ANNUAL REPORT REQUIRED PURSUANT TO SECTION 26-4-118 A SUMMARY OF ITS ONGOING ANALYSIS OF THE RESULTS OF THESE PROGRAMS AND SYSTEMS.

(6) **Graduate medical education.** (a) THE GENERAL ASSEMBLY DECLARES THAT GRADUATE MEDICAL EDUCATION, REFERRED TO IN THIS SUBSECTION (6) AS "GME" IS OF VALUE TO THE STATE AND THE PEOPLE OF COLORADO. THE GENERAL ASSEMBLY RECOGNIZES THAT MEDICAID MONEYS HAVE HISTORICALLY CONTRIBUTED TO THE FUNDING OF GME BY BEING INCLUDED IN THE RATE PAID TO TEACHING HOSPITALS UNDER THE MEDICAID FEE-FOR-SERVICE PROGRAM. THE GENERAL ASSEMBLY INTENDS THAT FISCAL SUPPORT FOR GME CONTINUE, BUT FINDS THAT UNDER A MANAGED CARE ENVIRONMENT, MCO'S WOULD HAVE NO OBLIGATION OR INCENTIVE TO CONTINUE THIS SUPPORT FOR GME.

(b) THE STATE DEPARTMENT SHALL CONTINUE THE GME FUNDING TO TEACHING HOSPITALS THAT HAVE GRADUATE MEDICAL EDUCATION EXPENSES IN THEIR MEDICARE COST REPORT AND ARE PARTICIPATING AS PROVIDERS UNDER ONE OR MORE MCO WITH A CONTRACT WITH THE STATE DEPARTMENT UNDER THIS SUBPART 2. GME FUNDING FOR RECIPIENTS ENROLLED IN AN MCO SHALL BE EXCLUDED FROM THE

PREMIUMS PAID TO THE MCO AND SHALL BE PAID DIRECTLY TO THE TEACHING HOSPITAL. THE MEDICAL SERVICES BOARD SHALL ADOPT RULES TO IMPLEMENT THIS SUBSECTION (6) AND ESTABLISH THE RATE AND METHOD OF REIMBURSEMENT.

(c) THIS SUBSECTION (6) SHALL BE IMPLEMENTED AS SOON AS PRACTICAL, BUT NOT LATER THAN JANUARY 1, 1998.

(7) **Annual savings report and use of savings.** (a) BY SEPTEMBER 1 OF EACH YEAR, THE STATE DEPARTMENT SHALL SUBMIT TO THE JOINT BUDGET COMMITTEE, THE HEALTH, ENVIRONMENT, WELFARE, AND INSTITUTIONS COMMITTEE OF THE SENATE, THE HEALTH, ENVIRONMENT, WELFARE, AND INSTITUTIONS COMMITTEE OF THE HOUSE OF REPRESENTATIVES, AND TO THE OFFICE OF STATE PLANNING AND BUDGETING A SAVINGS REPORT STATING THE COST SAVINGS REALIZED OR ANTICIPATED IN THE PREVIOUS, CURRENT, AND SUBSEQUENT STATE FISCAL YEARS FROM ENROLLMENT OF RECIPIENTS IN MANAGED CARE PROGRAMS PURSUANT TO THE PROVISIONS OF THIS SUBPART 2. THE REPORT SHALL INCLUDE AN ASSESSMENT OF THE EXTENT TO WHICH THE PROGRAM DESCRIBED IN SUBSECTION (8) OF THIS SECTION HAS REDUCED PROVIDERS' UNCOMPENSATED BURDENS AND AN ASSESSMENT OF CHANGES ON THE FINANCIAL VIABILITY OF ESSENTIAL COMMUNITY PROVIDERS. THE REPORT SHALL ALSO INCLUDE A RECOMMENDATION FOR PRIORITIZING BETWEEN THE SUBSIDIZED INSURANCE PROGRAM DESCRIBED IN SUBSECTION (8) OF THIS SECTION AND THE GRANTS PROGRAMS DESCRIBED IN SUBSECTION (9) OF THIS SECTION, AND FOR PRIORITIZING RESOURCES WITHIN EACH OF THOSE PROGRAMS TO DIFFERENT POPULATIONS AND REGIONS OF THE STATE. THESE RECOMMENDATIONS SHALL BE BASED UPON QUANTITATIVE AND QUALITATIVE ASSESSMENTS OF NEEDS AND ON THE RELATIVE COST-EFFECTIVENESS OF DIFFERENT RESOURCE ALLOCATIONS.

(b) IN CALCULATING COST SAVINGS FROM ENROLLMENT OF RECIPIENTS IN MANAGED CARE PROGRAMS, THE STATE DEPARTMENT SHALL CALCULATE THE TOTAL ANNUAL COST SAVINGS FROM GROWTH IN MANAGED CARE ENROLLMENT SUBSEQUENT TO JULY 1, 1997, AND TOTAL ANNUAL COST SAVINGS FROM ACTUAL REDUCTIONS IN ADMINISTRATIVE AND PROGRAMMATIC COSTS ASSOCIATED WITH THE IMPLEMENTATION OF THIS SUBPART 2. COST SAVINGS FOR EACH ADDITIONAL ENROLLEE SHALL BE CALCULATED AS THE DIFFERENCE IN PER CAPITA COST BETWEEN AN ENROLLEE IN FEE-FOR-SERVICE MEDICAID AND A SIMILAR ENROLLEE IN MANAGED CARE.

(c) THE GENERAL ASSEMBLY SHALL ANNUALLY APPROPRIATE ALL SAVINGS ACHIEVED THROUGH IMPLEMENTATION OF THIS SUBPART 2 AND DESCRIBED IN THIS SUBSECTION (7) TO COVER THE ADMINISTRATIVE COSTS OF IMPLEMENTING MANAGED CARE PURSUANT TO THE PROVISIONS OF THIS SUBPART 2 AND THE COSTS OF PROGRAMS PROVIDED IN SUBSECTIONS (8) AND (9) OF THIS SECTION AND ANY OTHER COST-EFFECTIVE OPTIONS TO EXPAND ACCESS TO SERVICES FOR THE MEDICALLY INDIGENT POPULATION. IT IS THE INTENT OF THE GENERAL ASSEMBLY THAT THE MANDATORY AND OPTIONAL POPULATIONS AND BENEFITS PROVIDED BY THE "COLORADO MEDICAL ASSISTANCE ACT" AS OF JUNE 30, 1997, ARE A HIGHER PRIORITY FOR FUNDING THAN THE WAIVERED OPTIONAL PROGRAMS DESCRIBED IN SUBSECTIONS (8) AND (9) OF THIS SECTION. SUCH APPROPRIATIONS SHALL INCLUDE ALL ANTICIPATED COST SAVINGS SUBSEQUENT TO JULY 1, 1997, THAT ARE ACHIEVED THROUGH THE IMPLEMENTATION OF THIS SUBPART 2 AND DESCRIBED IN THIS SUBSECTION (7). BEGINNING WITH AND SUBSEQUENT TO STATE FISCAL YEAR

1999-2000, SUCH APPROPRIATIONS SHALL INCLUDE ALL OF THE SAVINGS DESCRIBED IN THE ANNUAL SAVINGS REPORT DESCRIBED IN PARAGRAPH (a) OF THIS SUBSECTION (7).

(d) THE STATE DEPARTMENT SHALL MONITOR ACTUAL MANAGED CARE SAVINGS REALIZED DURING A PARTICULAR FISCAL YEAR BASED UPON THE METHODOLOGY DESCRIBED IN PARAGRAPH (b) OF THIS SUBSECTION (7). TO THE EXTENT THAT THE GENERAL ASSEMBLY HAS APPROPRIATED MANAGED CARE SAVINGS PURSUANT TO PARAGRAPH (c) OF THIS SUBSECTION (7) AND THE STATE DEPARTMENT DETERMINES THAT IT WILL NOT REALIZE ALL OF SUCH MANAGED CARE SAVINGS DURING A PARTICULAR FISCAL YEAR, THE STATE DEPARTMENT SHALL RESTRICT ITS SPENDING UNDER SUBSECTIONS (8) AND (9) OF THIS SECTION.

(e) TO IMPLEMENT THE PROVISIONS OF PARAGRAPH (d) OF THIS SUBSECTION (7), THE STATE DEPARTMENT SHALL SUBMIT SUPPLEMENTAL APPROPRIATION REQUESTS DURING A PARTICULAR FISCAL YEAR TO MODIFY APPROPRIATIONS FOR THE PROGRAMS DESCRIBED IN SUBSECTIONS (8) AND (9) OF THIS SECTION.

(f) THE STATE DEPARTMENT SHALL NOT SPEND MONEYS FROM MANAGED CARE SAVINGS ON THE PROGRAMS DESCRIBED IN SUBSECTIONS (8) AND (9) OF THIS SECTION DURING THE FISCAL YEAR BEGINNING JULY 1, 1997.

(8) **Subsidized insurance coverage.** (a) THERE IS HEREBY CREATED A SUBSIDIZED INSURANCE PROGRAM, REFERRED TO IN THIS SUBSECTION (8) AS THE "PROGRAM", THAT SHALL PROVIDE SUBSIDIZED INSURANCE COVERAGE FOR UNINSURED CHILDREN UNDER AGE NINETEEN. SUCH PROGRAM SHALL BE LIMITED TO PERSONS WITH FAMILIES WITH INCOMES LESS THAN OR EQUAL TO ONE HUNDRED EIGHTY-FIVE PERCENT OF THE FEDERAL POVERTY LEVEL. THE STATE DEPARTMENT IS HEREBY AUTHORIZED TO SEEK THE NECESSARY FEDERAL WAIVERS TO IMPLEMENT THE PROGRAM.

(b) NOTHING IN THIS SUBSECTION (8) OR ANY RULES PROMULGATED PURSUANT TO THE PROGRAM SHALL BE INTERPRETED TO CREATE A LEGAL ENTITLEMENT IN ANY PERSON TO SUBSIDIZED INSURANCE COVERAGE.

(c) ENROLLMENT IN THE PROGRAM SHALL BE LIMITED BASED UPON ANNUAL APPROPRIATIONS BY THE GENERAL ASSEMBLY AS DESCRIBED IN PARAGRAPH (c) OF SUBSECTION (7) OF THIS SECTION. THE GENERAL ASSEMBLY SHALL ANNUALLY ESTABLISH MAXIMUM ENROLLMENT FIGURES FOR CHILDREN.

(d) TO BE ELIGIBLE FOR A SUBSIDY UNDER THE PROGRAM, A CHILD MUST NOT HAVE CURRENTLY NOR IN THE THREE MONTHS PRIOR TO APPLICATION FOR THE PROGRAM HAVE BEEN INSURED BY A COMPARABLE HEALTH PLAN THROUGH AN EMPLOYER, WITH THE EMPLOYER CONTRIBUTING AT LEAST FIFTY PERCENT OF THE PREMIUM COST; EXCEPT THAT A CHILD WHO HAS LOST INSURANCE COVERAGE DUE TO A CHANGE IN OR LOSS OF EMPLOYMENT SHALL NOT BE SUBJECT TO THE THREE-MONTH WAITING PERIOD.

(e) IN IMPLEMENTING THIS PROGRAM, THE STATE DEPARTMENT SHALL CONTRACT FOR MANAGED CARE SERVICES WITH THE SAME GOALS AND UNDER THE SAME CONDITIONS AS THOSE DESCRIBED IN THIS SUBPART 2 AND SHALL SEEK TO PRIVATIZE

ADMINISTRATIVE FUNCTIONS IN THE SAME MANNER AS DESCRIBED IN SECTION 26-4-120.

(f) THE STATE DEPARTMENT SHALL DEFINE BENEFITS FOR THIS PROGRAM BASED UPON THE STANDARD AND BASIC HEALTH BENEFITS PLANS DESCRIBED IN ARTICLE 16 OF TITLE 10, C.R.S.

(g) THE STATE DEPARTMENT MAY REQUIRE ENROLLEES IN THE PROGRAM TO PAY A PORTION OF THE PREMIUM COSTS FOR THE PROGRAM AND PAY FOR A PORTION OF THE COST OF SERVICES DELIVERED UNDER THE PROGRAM. ON OR BEFORE JANUARY 1 OF EACH YEAR, THE STATE DEPARTMENT SHALL SUBMIT TO THE JOINT BUDGET COMMITTEE ITS PROPOSAL FOR A SCALE FOR INCREASING PREMIUMS OR SERVICE COST SHARING FOR THE PROGRAM BASED UPON A FAMILY'S INCOME.

(h) THE STATE DEPARTMENT SHALL ESTABLISH PROCEDURES FOR RECEIVING PART OR ALL OF THE REQUIRED PREMIUM PAYMENTS UNDER THE PROGRAM FROM OTHER HEALTH CARE PURCHASERS AND SHALL ESTABLISH PROCEDURES FOR BUYING HEALTH CARE INSURANCE WITH SUBSTANTIALLY SIMILAR BENEFITS TO THOSE UNDER THE PROGRAM THROUGH OTHER HEALTH CARE PURCHASERS.

(i) THE STATE DEPARTMENT MAY ESTABLISH RULES UNDER THE PROGRAM FOR DETERMINING ELIGIBILITY AND FOR ENROLLING ELIGIBLE PERSONS IN MANAGED CARE PLANS THAT ARE DIFFERENT FROM THE MEDICAL ASSISTANCE PROGRAM.

(j) IN IMPLEMENTING THE PROGRAM, THE STATE DEPARTMENT SHALL SEEK TO ACHIEVE A DISTRIBUTION OF ENROLLMENT IN THE PROGRAM BY COUNTY THAT IS AS SIMILAR AS POSSIBLE TO THE DISTRIBUTION OF ENROLLMENT IN CAPITATED MEDICAID MANAGED CARE PROGRAMS BY COUNTY.

(9) **Grants programs.** (a) SUBJECT TO APPROPRIATIONS AS DESCRIBED IN PARAGRAPH (c) OF SUBSECTION (7) OF THIS SECTION, THERE IS HEREBY CREATED A GRANT PROGRAM THAT SHALL BE ADMINISTERED BY THE STATE DEPARTMENT. THE PURPOSE OF THE GRANT PROGRAM IS TO ASSIST ESSENTIAL COMMUNITY PROVIDERS TO SERVE THE MEDICALLY INDIGENT POPULATION AND TO IDENTIFY AND IMPLEMENT ADDITIONAL COST-EFFECTIVE OPTIONS TO EXPAND ACCESS TO SERVICES FOR SAID POPULATION.

(b) THE STATE DEPARTMENT SHALL PROMULGATE RULES FOR THE IMPLEMENTATION OF THE GRANT PROGRAM THAT SHALL INCLUDE BUT NOT BE LIMITED TO:

(I) PROCEDURES FOR APPLYING FOR A GRANT UNDER THIS SECTION;

(II) METHODS FOR THE EVALUATION OF APPLICATIONS FOR GRANTS UNDER THIS SECTION AND AWARD OF GRANTS UNDER THIS SUBSECTION (9); AND

(III) METHODS FOR EVALUATING THE GRANT PROGRAM.

(10) (a) BY NOVEMBER 1, 1997, THE STATE DEPARTMENT SHALL SUBMIT TO THE JOINT BUDGET COMMITTEE, THE HEALTH, ENVIRONMENT, WELFARE, AND INSTITUTIONS COMMITTEE OF THE SENATE, AND THE HEALTH, ENVIRONMENT, WELFARE, AND

INSTITUTIONS COMMITTEE OF THE HOUSE OF REPRESENTATIVES A REPORT ON A PLAN TO DEVELOP A DENTAL SERVICES PROGRAM THAT ASSURES ACCESS TO DENTAL SERVICES FOR CHILDREN IN THE MEDICAID PROGRAM. ANY DENTAL RATE INCREASE MAY BE EFFECTIVE ON OR AFTER JULY 1, 1998.

(b) THIS SUBSECTION (10) IS REPEALED, EFFECTIVE JULY 1, 1998.

26-4-114. Managed care organizations - definitions. (1) (a) **Managed care.** AS USED IN THIS SUBPART 2, "MANAGED CARE" MEANS:

(I) THE DELIVERY BY A MANAGED CARE ORGANIZATION, AS DEFINED IN SUBSECTION (2) OF THIS SECTION, OF A PREDEFINED SET OF SERVICES TO RECIPIENTS; OR

(II) THE DELIVERY OF SERVICES PROVIDED BY THE PRIMARY CARE PHYSICIAN PROGRAM ESTABLISHED IN SECTION 26-4-118.

(b) NOTHING IN THIS SECTION SHALL BE DEEMED TO AFFECT THE BENEFITS AUTHORIZED FOR RECIPIENTS OF THE STATE MEDICAL ASSISTANCE PROGRAM.

(2) **Managed care organization.** AS USED IN THIS SUBPART 2, "MANAGED CARE ORGANIZATION" MEANS AN ENTITY CONTRACTING WITH THE STATE DEPARTMENT THAT PROVIDES, DELIVERS, ARRANGES FOR, PAYS FOR, OR REIMBURSES ANY OF THE COSTS OF HEALTH CARE SERVICES THROUGH THE RECIPIENT'S USE OF HEALTH CARE PROVIDERS MANAGED BY, OWNED BY, UNDER CONTRACT WITH, OR EMPLOYED BY THE ENTITY BECAUSE THE ENTITY OR THE STATE DEPARTMENT EITHER REQUIRES THE RECIPIENT'S USE OF THOSE PROVIDERS OR CREATES INCENTIVES, INCLUDING FINANCIAL INCENTIVES, FOR THE RECIPIENT'S USE OF THOSE PROVIDERS.

(3) **Essential community provider.** "ESSENTIAL COMMUNITY PROVIDER" OR "ECP" MEANS A HEALTH CARE PROVIDER THAT:

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

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

26-4-115. Selection of managed care organizations. (1) THE MEDICAL SERVICES BOARD AFTER PUBLIC HEARING AND INPUT FROM RECIPIENTS, THEIR ADVOCATES, AND PROVIDERS SHALL ESTABLISH CRITERIA FOR THE SELECTION OF RISK-ASSUMING MCO'S.

(2) MCO'S SHALL BE SELECTED BY THE STATE DEPARTMENT TO PARTICIPATE IN THE STATEWIDE MANAGED CARE SYSTEM BASED UPON THE MCO'S ASSURANCE AND THE STATE DEPARTMENT'S VERIFICATION OF COMPLIANCE WITH SPECIFIC CRITERIA SET BY THE MEDICAL SERVICES BOARD PURSUANT TO THIS SUBSECTION (2) THAT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING:

(a) THE MCO WILL NOT INTERFERE WITH APPROPRIATE MEDICAL CARE DECISIONS RENDERED BY THE PROVIDER NOR PENALIZE THE PROVIDER FOR REQUESTING MEDICAL SERVICES OUTSIDE THE STANDARD TREATMENT PROTOCOLS DEVELOPED BY THE MCO OR ITS CONTRACTORS;

(b) THE MCO WILL MAKE OR ASSURE PAYMENTS TO PROVIDERS WITHIN THE TIME ALLOWED FOR THE STATE TO MAKE PAYMENTS ON STATE LIABILITIES UNDER THE RULES ADOPTED BY THE DEPARTMENT OF PERSONNEL PURSUANT TO SECTION 24-30-202 (13), C.R.S.;

(c) AN EDUCATIONAL COMPONENT IN THE MCO'S PLAN THAT TAKES INTO CONSIDERATION RECIPIENT INPUT AND THAT INFORMS RECIPIENTS AS TO AVAILABILITY OF PLANS AND USE OF THE MEDICAL SERVICES SYSTEM, APPROPRIATE PREVENTIVE HEALTH CARE PROCEDURES, SELF-CARE, AND APPROPRIATE HEALTH CARE UTILIZATION;

(d) MINIMUM BENEFIT REQUIREMENTS AS ESTABLISHED BY THE MEDICAL SERVICES BOARD;

(e) PROVISION OF NECESSARY AND APPROPRIATE SERVICES TO RECIPIENTS THAT SHALL INCLUDE BUT NOT BE LIMITED TO THE FOLLOWING:

(I) WITH RESPECT TO RECIPIENTS WHO ARE UNABLE TO MAKE DECISIONS FOR THEMSELVES, COLLABORATION BY THE MCO AND ALL RELEVANT PROVIDERS IN THE MCO'S NETWORK SERVING THE RECIPIENTS WITH THE DESIGNATED ADVOCATE OR FAMILY MEMBER IN ALL DECISION-MAKING INCLUDING ENROLLMENT AND DISENROLLMENT;

(II) DELIVERY OF SERVICES THAT ARE COVERED BENEFITS IN A MANNER THAT ACCOMMODATES OR IS COMPATIBLE WITH THE RECIPIENT'S ABILITY TO FULFILL DUTIES AND RESPONSIBILITIES IN WORK AND COMMUNITY ACTIVITIES.

(f) APPROPRIATE USE OF ANCILLARY HEALTH CARE PROVIDERS BY APPROPRIATE QUALIFIED HEALTH CARE PROFESSIONALS;

(g) DATA COLLECTION AND REPORTING REQUIREMENTS ESTABLISHED BY THE MEDICAL SERVICES BOARD;

(h) TO THE EXTENT PROVIDED BY LAW OR WAIVER, PROVISION OF RECIPIENT BENEFITS THAT THE MEDICAL SERVICES BOARD SHALL DEVELOP AND THE STATE DEPARTMENT SHALL IMPLEMENT IN PARTNERSHIP WITH LOCAL GOVERNMENT AND THE PRIVATE SECTOR, INCLUDING BUT NOT LIMITED TO:

(I) RECIPIENT OPTIONS TO RENT, PURCHASE, OR OWN DURABLE MEDICAL EQUIPMENT;

(II) RECOGNITION FOR IMPROVED HEALTH STATUS OUTCOMES; OR

(III) RECEIPT OF MEDICAL DISPOSABLE SUPPLIES WITHOUT CHARGE;

(i) UTILIZATION REQUIREMENTS ESTABLISHED BY THE STATE DEPARTMENT;

(j) A FORM OR PROCESS FOR MEASURING GROUP AND INDIVIDUAL RECIPIENT HEALTH OUTCOMES, INCLUDING BUT NOT LIMITED TO THE USE OF TOOLS OR METHODS THAT IDENTIFY INCREASED HEALTH STATUS OR MAINTENANCE OF THE INDIVIDUAL'S HIGHEST LEVEL OF FUNCTIONING, DETERMINE THE DEGREE OF MEDICAL ACCESS, AND REVEAL RECIPIENT SATISFACTION AND HABITS. SUCH TOOLS SHALL INCLUDE THE USE OF CLIENT SURVEYS, ANECDOTAL INFORMATION, COMPLAINT AND GRIEVANCE DATA, AND DISENROLLMENT INFORMATION. THE MCO SHALL ANNUALLY SUBMIT A CARE MANAGEMENT REPORT TO THE STATE DEPARTMENT THAT DESCRIBES TECHNIQUES USED BY THE MCO TO PROVIDE MORE EFFICIENT USE OF HEALTH CARE SERVICES, BETTER HEALTH STATUS FOR POPULATIONS SERVED, AND BETTER HEALTH OUTCOMES FOR INDIVIDUALS.

(k) FINANCIAL STABILITY OF THE MCO;

(l) ASSURANCE THAT THE MCO HAS NOT PROVIDED TO A RECIPIENT ANY PREMIUMS OR OTHER INDUCEMENTS IN EXCHANGE FOR THE RECIPIENT SELECTING THE MCO FOR COVERAGE;

(m) A GRIEVANCE PROCEDURE PURSUANT TO THE PROVISIONS IN SECTION 26-4-117 (1) (b) THAT ALLOWS FOR THE TIMELY RESOLUTION OF DISPUTES REGARDING THE QUALITY OF CARE, SERVICES TO BE PROVIDED, AND OTHER ISSUES RAISED BY THE RECIPIENT. MATTERS SHALL BE RESOLVED IN A MANNER CONSISTENT WITH THE MEDICAL NEEDS OF THE INDIVIDUAL RECIPIENT. PURSUANT TO SECTION 25.5-1-107, C.R.S., A RECIPIENT MAY SEEK AN ADMINISTRATIVE REVIEW OF AN ADVERSE DECISION MADE BY THE MCO.

(n) WITH RESPECT TO PREGNANT WOMEN AND INFANTS, THE FOLLOWING:

(I) ENROLLMENT OF PREGNANT WOMEN WITHOUT RESTRICTIONS AND INCLUDING AN ASSURANCE THAT THE HEALTH CARE PROVIDER SHALL PROVIDE TIMELY ACCESS TO INITIATION OF PRENATAL CARE IN ACCORDANCE WITH PRACTICE STANDARDS;

(II) COVERAGE WITHOUT RESTRICTIONS FOR NEWBORNS, INCLUDING SERVICES SUCH AS, BUT NOT LIMITED TO, PREVENTIVE CARE, SCREENING, AND WELL-BABY EXAMINATIONS DURING THE FIRST MONTH OF LIFE;

(III) THE IMPOSITION OF PERFORMANCE STANDARDS AND THE USE OF QUALITY INDICATORS WITH RESPECT TO PERINATAL, PRENATAL, AND POSTPARTUM CARE FOR WOMEN AND BIRTHING AND NEONATAL CARE FOR INFANTS. THE STANDARDS AND INDICATORS SHALL BE BASED ON NATIONALLY APPROVED GUIDELINES.

(IV) FOLLOW-UP BASIC HEALTH MAINTENANCE SERVICES FOR WOMEN AND CHILDREN, INCLUDING IMMUNIZATIONS AND EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES FOR CHILDREN AND APPROPRIATE PREVENTIVE CARE SERVICES FOR WOMEN;

(o) THE MCO WILL ACCEPT ALL ENROLLEES REGARDLESS OF HEALTH STATUS CONSISTENT WITH THE PROVISIONS OF SECTION 26-4-118;

(p) DISCLOSURE REQUIREMENTS AS ESTABLISHED BY THE STATE DEPARTMENT AND MEDICAL SERVICES BOARD;

(q) PROVIDE A MECHANISM WHEREBY A PRESCRIBING PHYSICIAN CAN REQUEST TO OVERRIDE RESTRICTIONS TO OBTAIN MEDICALLY NECESSARY OFF-FORMULARY PRESCRIPTION DRUGS, SUPPLIES, EQUIPMENT, OR SERVICES FOR HIS OR HER PATIENT;

(r) MAINTENANCE OF A NETWORK OF PROVIDERS SUFFICIENT TO ASSURE THAT ALL SERVICES TO RECIPIENTS WILL BE ACCESSIBLE WITHOUT UNREASONABLE DELAY. THE STATE DEPARTMENT SHALL DEVELOP EXPLICIT CONTRACT STANDARDS, IN CONSULTATION WITH STAKEHOLDERS, TO ASSESS AND MONITOR THE MCO'S CRITERIA. SUFFICIENCY SHALL BE DETERMINED IN ACCORDANCE WITH THE REQUIREMENTS OF THIS PARAGRAPH (r) AND MAY BE ESTABLISHED BY REFERENCE TO ANY REASONABLE CRITERIA USED BY THE MCO INCLUDING BUT NOT LIMITED TO THE FOLLOWING:

(I) GEOGRAPHIC ACCESSIBILITY IN REGARD TO THE SPECIAL NEEDS OF RECIPIENTS;

(II) WAITING TIMES FOR APPOINTMENTS WITH PARTICIPATING PROVIDERS;

(III) HOURS OF OPERATION;

(IV) VOLUME OF TECHNOLOGICAL AND SPECIALTY SERVICES AVAILABLE TO SERVE THE NEEDS OF RECIPIENTS REQUIRING TECHNOLOGICALLY ADVANCED OR SPECIALTY CARE.

(s) (I) FOR THE DELIVERY OF PRESCRIPTION DRUG BENEFITS TO RECIPIENTS ENROLLED IN AN MCO WHO ARE RESIDENTS OF A NURSING FACILITY, MCO'S SHALL USE PHARMACIES WITH A DEMONSTRATED CAPABILITY OF PROVIDING PRESCRIPTION DRUGS IN A MANNER CONSISTENT WITH THE NEEDS OF CLIENTS IN INSTITUTIONAL SETTINGS SUCH AS NURSING FACILITIES. IN CASES WHERE A NURSING FACILITY AND A PHARMACY HAVE A CONTRACT FOR A SINGLE PHARMACY DELIVERY SYSTEM FOR RESIDENTS OF THE NURSING FACILITY:

(A) AN MCO PROVIDING PRESCRIPTION DRUG BENEFITS FOR RESIDENTS OF THE NURSING FACILITY SHALL AGREE TO CONTRACT WITH THAT PHARMACY UNDER REASONABLE CONTRACT TERMS; AND

(B) THE PHARMACY SHALL AGREE TO CONTRACT WITH EACH MCO THAT PROVIDES PRESCRIPTION DRUG BENEFITS FOR RESIDENTS OF THE NURSING FACILITY UNDER REASONABLE CONTRACT TERMS.

(II) ANY DISPUTES CONCERNING PROVIDING PRESCRIPTION DRUG BENEFITS BETWEEN NURSING FACILITIES, PHARMACIES, AND MCO'S THAT CANNOT BE RESOLVED THROUGH GOOD FAITH NEGOTIATIONS MAY BE RESOLVED THROUGH A PARTY REQUESTING AN INFORMAL REVIEW BY THE STATE DEPARTMENT OR, IF REQUESTED, A HEARING THROUGH THE STATE DEPARTMENT'S AGGRIEVED PROVIDER APPEAL PROCEDURES IN ACCORDANCE WITH SECTION 25.5-1-107 (2), C.R.S.

(III) THE MEDICAL SERVICES BOARD SHALL ADOPT RULES REQUIRING MCO'S TO CONTRACT WITH QUALIFIED PHARMACY PROVIDERS IN A MANNER PERMITTING A NURSING FACILITY TO CONTINUE TO COMPLY WITH FEDERAL MEDICAID REQUIREMENTS OF PARTICIPATION FOR NURSING FACILITIES. SUCH RULES SHALL DEFINE "QUALIFIED PHARMACY PROVIDERS" AND SHALL BE BASED UPON CONSULTATIONS WITH NURSING FACILITIES, MCO'S, PHARMACIES, AND MEDICAID CLIENTS. THE STATE DEPARTMENT

SHALL PROVIDE MCO'S WITH A LIST OF PHARMACIES THAT HAVE A CONTRACT WITH NURSING FACILITIES SERVING RECIPIENTS IN NURSING FACILITIES IN EACH COUNTY IN WHICH THE MCO IS CONTRACTING WITH THE STATE DEPARTMENT.

(3) (a) THE MCO SHALL SEEK PROPOSALS FROM EACH ECP IN A COUNTY IN WHICH THE MCO IS ENROLLING RECIPIENTS FOR THOSE SERVICES THAT THE MCO PROVIDES OR INTENDS TO PROVIDE AND THAT AN ECP PROVIDES OR IS CAPABLE OF PROVIDING. TO ASSIST MCO'S IN SEEKING PROPOSALS, THE STATE DEPARTMENT SHALL PROVIDE MCO'S WITH A LIST OF ECP'S IN EACH COUNTY. THE MCO SHALL CONSIDER SUCH PROPOSALS IN GOOD FAITH AND SHALL, WHEN DEEMED REASONABLE BY THE MCO BASED ON THE NEEDS OF ITS ENROLLEES, CONTRACT WITH ECP'S. EACH ECP SHALL BE WILLING TO NEGOTIATE ON REASONABLY EQUITABLE TERMS WITH EACH MCO. ECP'S MAKING PROPOSALS UNDER THIS SUBSECTION (3) MUST BE ABLE TO MEET THE CONTRACTUAL REQUIREMENTS OF THE MCO. THE REQUIREMENTS OF THIS SUBSECTION (3) SHALL NOT APPLY TO AN MCO IN AREAS IN WHICH THE MCO OPERATES ENTIRELY AS A GROUP MODEL HEALTH MAINTENANCE ORGANIZATION.

(b) ANY DISPUTES BETWEEN AN MCO AND AN ECP THAT CANNOT BE RESOLVED THROUGH GOOD FAITH NEGOTIATIONS MAY BE RESOLVED THROUGH A PARTY REQUESTING AN INFORMAL REVIEW BY THE STATE DEPARTMENT, OR, IF REQUESTED, A HEARING THROUGH THE STATE DEPARTMENT'S AGGRIEVED PROVIDER APPEAL PROCESS IN ACCORDANCE WITH SECTION 25.5-1-107 (2), C.R.S.

(4) IN SELECTING MCO'S THROUGH COMPETITIVE BIDDING, THE STATE DEPARTMENT SHALL GIVE PREFERENCE TO THOSE MCO'S THAT HAVE EXECUTED CONTRACTS FOR SERVICES WITH ONE OR MORE ECP. IN SELECTING MCO'S, THE STATE DEPARTMENT SHALL NOT PENALIZE AN MCO FOR PAYING COST-BASED REIMBURSEMENT TO FEDERALLY QUALIFIED HEALTH CENTERS AS DEFINED IN THE "SOCIAL SECURITY ACT".

(5) (a) NOTWITHSTANDING ANY WAIVERS AUTHORIZED BY THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES, EACH CONTRACT BETWEEN THE STATE DEPARTMENT AND AN MCO SELECTED TO PARTICIPATE IN THE STATEWIDE MANAGED CARE SYSTEM UNDER THIS SUBPART 2 SHALL COMPLY WITH THE REQUIREMENTS OF 42 U.S.C. SEC. 1396a (a) (23) (B).

(b) EACH MCO SHALL ADVISE ITS ENROLLEES OF THE SERVICES AVAILABLE PURSUANT TO THIS SUBSECTION (5).

(6) NOTHING IN THIS SUBPART 2 SHALL BE CONSTRUED TO CREATE AN EXEMPTION FROM THE APPLICABLE PROVISIONS OF TITLE 10, C.R.S.

26-4-116. Quality measurements. (1) THE STATE DEPARTMENT SHALL MEASURE QUALITY PURSUANT TO THE FOLLOWING CRITERIA:

(a) QUALITY SHALL BE MEASURED AND CONSIDERED BASED UPON INDIVIDUALS AND GROUPS WITH THE SATISFACTION OF THE SERVICE RECEIVED ANALYZED AND COMPARED TO NONRECIPIENT POPULATIONS FOR THE SAME OR SIMILAR SERVICES WHEN AVAILABLE.

(b) QUALITY SHALL FOCUS ON HEALTH STATUS OR MAINTENANCE OF THE

INDIVIDUAL'S HIGHEST LEVEL OF FUNCTIONING, WITHOUT STRICT ADHERENCE TO STATISTICAL NORMS.

(2) THE STATE DEPARTMENT SHALL PROMULGATE RULES AND REGULATIONS TO CLARIFY AND ADMINISTER QUALITY MEASUREMENTS.

26-4-117. Required features of managed care system. (1) **General features.** ALL MEDICAID MANAGED CARE PROGRAMS SHALL CONTAIN THE FOLLOWING GENERAL FEATURES, IN ADDITION TO OTHERS THAT THE STATE DEPARTMENT AND THE MEDICAL SERVICES BOARD CONSIDER NECESSARY FOR THE EFFECTIVE AND COST-EFFICIENT OPERATION OF THOSE PROGRAMS:

(a) **Recipient selection of MCO's.** (I) THE GENERAL ASSEMBLY FINDS THAT THE ABILITY OF RECIPIENTS TO CHOOSE AMONG COMPETING HEALTH PLANS OR HEALTH DELIVERY SYSTEMS IS AN IMPORTANT TOOL IN ENCOURAGING SUCH PLANS AND DELIVERY SYSTEMS TO COMPETE FOR ENROLLEES ON THE BASIS OF QUALITY AND ACCESS. THE STATE DEPARTMENT SHALL, TO THE EXTENT IT DETERMINES FEASIBLE, PROVIDE MEDICAID-ELIGIBLE RECIPIENTS A CHOICE AMONG COMPETING MCO'S AND A CHOICE AMONG PROVIDERS WITHIN AN MCO. CONSISTENT WITH FEDERAL REQUIREMENTS AND RULES PROMULGATED BY THE MEDICAL SERVICES BOARD, THE STATE DEPARTMENT IS AUTHORIZED TO ASSIGN A MEDICAID RECIPIENT TO A PARTICULAR MCO OR PRIMARY CARE PHYSICIAN IF:

(A) NO OTHER MCO OR PRIMARY CARE PHYSICIAN HAS THE CAPACITY OR EXPERTISE NECESSARY TO SERVE THE RECIPIENT; OR

(B) A RECIPIENT DOES NOT RESPOND WITHIN TWENTY DAYS AFTER THE DATE OF A SECOND NOTIFICATION OF A REQUEST FOR SELECTION OF AN MCO OR PRIMARY CARE PHYSICIAN SENT NOT LESS THAN FORTY-FIVE DAYS AFTER DELIVERY OF A FIRST NOTIFICATION.

(II) CONSUMERS SHALL BE INFORMED OF THE CHOICES AVAILABLE IN THEIR AREA BY APPROPRIATE SOURCES OF INFORMATION AND COUNSELING. THIS SHALL INCLUDE AN INDEPENDENT, OBJECTIVE FACILITATOR ACTING UNDER THE SUPERVISION OF THE STATE DEPARTMENT. THE STATE DEPARTMENT SHALL CONTRACT FOR THE FACILITATOR THROUGH A COMPETITIVE BIDDING PROCESS. THIS FUNCTION SHALL ENSURE THAT CONSUMERS HAVE INFORMED CHOICE AMONG AVAILABLE OPTIONS TO ASSURE THE FULLEST POSSIBLE VOLUNTARY PARTICIPATION IN MANAGED CARE. THE FACILITATOR SHALL ATTEMPT TO COLLECT AND CONSIDER, AT A MINIMUM, A CONSUMER'S USUAL AND HISTORIC SOURCES OF CARE, LINGUISTIC NEEDS, SPECIAL MEDICAL NEEDS, AND TRANSPORTATION NEEDS. THE FACILITATOR SHALL, IF THE ENROLLEE REQUESTS, ACT AS THE ENROLLEE'S REPRESENTATIVE IN RESOLVING COMPLAINTS AND GRIEVANCES WITH THE MCO. THE DEPARTMENT, IN CONJUNCTION WITH THE MEDICAL SERVICES BOARD, SHALL ADOPT REGULATIONS SETTING FORTH MINIMUM DISCLOSURE REQUIREMENTS FOR ALL MCO'S. ONCE A RECIPIENT IS ENROLLED IN AN MCO, THE RECIPIENT MAY NOT CHANGE TO A DIFFERENT MCO FOR A PERIOD OF SIX MONTHS EXCEPT FOR GOOD CAUSE AS DETERMINED BY THE STATE DEPARTMENT. GOOD CAUSE SHALL INCLUDE BUT NEED NOT BE LIMITED TO ADMINISTRATIVE ERROR AND AN MCO'S INABILITY TO PROVIDE ITS COVERED SERVICES TO A RECIPIENT AFTER REASONABLE EFFORTS ON THE PART OF THE MCO AND THE RECIPIENT, AS DEFINED BY THE MEDICAL SERVICES BOARD. BASED UPON ITS

ASSESSMENT OF ANY SPECIAL NEEDS OF RECIPIENTS WITH COGNITIVE DISABILITIES, THE MEDICAL SERVICES BOARD MAY ADOPT RULES RELATING TO ANY NECESSARY GOOD CAUSE PROVISIONS FOR RECIPIENTS WITH COGNITIVE DISABILITIES WHO ARE ASSIGNED TO A PARTICULAR MCO PURSUANT TO SUBPARAGRAPH (I) OF THIS PARAGRAPH (a).

(III) WHEN ELIGIBLE CONSUMERS CHOOSE TO CHANGE OR DISENROLL FROM THEIR SELECTED MCO, THE STATE DEPARTMENT SHALL MONITOR AND GATHER DATA ABOUT THE REASONS FOR DISENROLLING, INCLUDING DENIAL OF ENROLLMENT OR DISENROLLMENT DUE TO AN ACT OR OMISSION OF AN MCO. THE STATE DEPARTMENT SHALL ANALYZE THIS DATA AND PROVIDE FEEDBACK TO THE PLANS OR PROVIDERS AND SHALL USE THE INFORMATION IN THE STATE DEPARTMENT'S CONTRACTING AND QUALITY ASSURANCE EFFORTS. PERSONS WHO HAVE BEEN DENIED ENROLLMENT OR HAVE DISENROLLED DUE TO AN ACT OR OMISSION OF AN MCO MAY SEEK REVIEW BY AN INDEPENDENT HEARING OFFICER, AS PROVIDED FOR AND REQUIRED UNDER FEDERAL LAW AND ANY STATE STATUTE OR REGULATION.

(b) **Complaints and grievances.** EACH MCO SHALL UTILIZE A COMPLAINT AND GRIEVANCE PROCEDURE AND A PROCESS FOR EXPEDITED REVIEWS THAT COMPLY WITH REGULATIONS ESTABLISHED BY THE STATE DEPARTMENT IN CONFORMITY WITH FEDERAL LAW. THE COMPLAINT AND GRIEVANCE PROCEDURE SHALL PROVIDE A MEANS BY WHICH ENROLLEES MAY COMPLAIN ABOUT OR GRIEVE ANY ACTION OR FAILURE TO ACT THAT IMPACTS AN ENROLLEE'S ACCESS TO, SATISFACTION WITH, OR THE QUALITY OF HEALTH CARE SERVICES, TREATMENTS, OR PROVIDERS. THE PROCESS FOR EXPEDITED REVIEWS SHALL PROVIDE A MEANS BY WHICH AN ENROLLEE MAY COMPLAIN AND SEEK RESOLUTION CONCERNING ANY ACTION OR FAILURE TO ACT IN AN EMERGENCY SITUATION THAT IMMEDIATELY IMPACTS THE ENROLLEE'S ACCESS TO QUALITY HEALTH CARE SERVICES, TREATMENTS, OR PROVIDERS. AN ENROLLEE SHALL BE ENTITLED TO DESIGNATE A REPRESENTATIVE, INCLUDING BUT NOT LIMITED TO AN ATTORNEY, A FACILITATOR DESCRIBED IN PARAGRAPH (a) OF THIS SUBSECTION (1), A LAY ADVOCATE, OR THE ENROLLEE'S PHYSICIAN, TO FILE AND PURSUE A GRIEVANCE OR EXPEDITED REVIEW ON BEHALF OF THE ENROLLEE. THE PROCEDURE SHALL ALLOW FOR THE UNENCUMBERED PARTICIPATION OF PHYSICIANS. AN ENROLLEE WHOSE COMPLAINT OR GRIEVANCE IS NOT RESOLVED TO HIS OR HER SATISFACTION BY A PROCEDURE DESCRIBED IN THIS PARAGRAPH (b) OR WHO CHOOSES TO FOREGO A PROCEDURE DESCRIBED IN THIS PARAGRAPH (b) SHALL BE ENTITLED TO REQUEST A SECOND-LEVEL REVIEW BY AN INDEPENDENT HEARING OFFICER, FURTHER JUDICIAL REVIEW, OR BOTH, AS PROVIDED FOR BY FEDERAL LAW AND ANY STATE STATUTE OR REGULATION. THE STATE DEPARTMENT MAY ALSO PROVIDE BY REGULATION FOR ARBITRATION AS AN OPTIONAL ALTERNATIVE TO THE COMPLAINT AND GRIEVANCE PROCEDURE SET FORTH IS THIS PARAGRAPH (b) TO THE EXTENT THAT SUCH REGULATIONS DO NOT VIOLATE ANY OTHER STATE OR FEDERAL STATUTORY OR CONSTITUTIONAL REQUIREMENTS.

(c) **Billing medicaid recipients.** NOTWITHSTANDING ANY FEDERAL REGULATIONS OR THE GENERAL PROHIBITION OF SECTION 26-4-403 AGAINST PROVIDERS BILLING MEDICAID RECIPIENTS, A PROVIDER MAY BILL A MEDICAID RECIPIENT WHO IS ENROLLED WITH A SPECIFIC MEDICAID PRIMARY CARE PHYSICIAN OR MCO AND, IN CIRCUMSTANCES DEFINED BY THE REGULATIONS OF THE MEDICAL SERVICES BOARD, RECEIVES CARE FROM A MEDICAL PROVIDER OUTSIDE THAT ORGANIZATION'S NETWORK OR WITHOUT REFERRAL BY THE RECIPIENT'S PRIMARY CARE PHYSICIAN.

(d) **Marketing.** IN MARKETING COVERAGE TO MEDICAID RECIPIENTS, ALL MCO'S SHALL COMPLY WITH ALL APPLICABLE PROVISIONS OF TITLE 10, C.R.S., REGARDING HEALTH PLAN MARKETING. THE MEDICAL SERVICES BOARD IS AUTHORIZED TO PROMULGATE RULES CONCERNING THE PERMISSIBLE MARKETING OF MEDICAID MANAGED CARE. THE PURPOSES OF SUCH RULES SHALL INCLUDE BUT NOT BE LIMITED TO THE AVOIDANCE OF BIASED SELECTION AMONG THE CHOICES AVAILABLE TO MEDICAID RECIPIENTS.

(e) **Prescription drugs.** ALL MCO'S SHALL PROVIDE PRESCRIPTION DRUG COVERAGE AS PART OF A COMPREHENSIVE HEALTH BENEFIT AND WITH RESPECT TO ANY FORMULARY OR OTHER ACCESS RESTRICTIONS:

(I) THE MCO SHALL SUPPLY PARTICIPATING PROVIDERS WHO MAY PRESCRIBE PRESCRIPTION DRUGS FOR MCO ENROLLEES WITH A CURRENT COPY OF SUCH FORMULARY OR OTHER ACCESS RESTRICTIONS, INCLUDING INFORMATION ABOUT COVERAGE, PAYMENT, OR ANY REQUIREMENT FOR PRIOR AUTHORIZATION; AND

(II) THE MCO SHALL PROVIDE TO ALL MEDICAID RECIPIENTS AT PERIODIC INTERVALS, AND PRIOR TO AND DURING ENROLLMENT UPON REQUEST, CLEAR AND CONCISE INFORMATION ABOUT THE PRESCRIPTION DRUG PROGRAM IN LANGUAGE UNDERSTANDABLE TO THE MEDICAID RECIPIENTS, INCLUDING INFORMATION ABOUT SUCH FORMULARY OR OTHER ACCESS RESTRICTIONS AND PROCEDURES FOR GAINING ACCESS TO PRESCRIPTION DRUGS, INCLUDING OFF-FORMULARY PRODUCTS.

(f) **Access to prescription drugs.** (I) THE STATE DEPARTMENT SHALL ENCOURAGE AN MCO TO SOLICIT COMPETITIVE BIDS FOR THE PRESCRIPTION DRUG BENEFIT AND DISCOURAGE AN MCO FROM CONTRACTING FOR THE PRESCRIPTION DRUG BENEFIT WITH A SOLE SOURCE PROVIDER AS MUCH AS POSSIBLE. THE STATE DEPARTMENT'S REPORTS REQUIRED BY SECTION 26-4-121 SHALL INCLUDE A SUMMARY OF EACH MCO'S PHARMACY NETWORK BY GEOGRAPHIC CATCHMENT AREA.

(II) IF AN MCO SOLICITS COMPETITIVE BIDS FOR THE PRESCRIPTION DRUG BENEFIT, THE MCO SHALL REQUEST BIDS FROM EACH PHARMACY PROVIDER LOCATED IN THE GEOGRAPHIC AREAS IN WHICH THE MCO IS SOLICITING BIDS. ALL MCO'S SHALL FOLLOW A REASONABLE STANDARD FOR RECIPIENT ACCESS TO PRESCRIPTION DRUGS. AT A MINIMUM, THE STATE DEPARTMENT SHALL VERIFY COMPLIANCE WITH THESE REQUIREMENTS BY REVIEWING EVIDENCE PROVIDED BY THE COMMISSIONER OF INSURANCE CONCERNING COMPLIANCE WITH ANY STANDARDS OR GUIDANCE ESTABLISHED BY THE COMMISSIONER OF INSURANCE FOR CONSUMER ACCESS TO PRESCRIPTION DRUGS.

(III) THE STANDARDS AND GUIDANCE FROM THE INSURANCE COMMISSIONER SHALL BE BASED ON THE FOLLOWING:

(A) PROCEDURES THAT AN MCO SHALL FOLLOW TO ENSURE THAT PHARMACIES IN RURAL COMMUNITIES WITH FEWER THAN TWENTY-FIVE THOUSAND PERSONS HAVE THE OPPORTUNITY TO JOIN RETAIL PRESCRIPTION DRUG NETWORKS IF THEY AGREE TO REASONABLE CONTRACT TERMS;

(B) PROCEDURES THAT AN MCO SHALL FOLLOW TO NOTIFY THE PHARMACY COMMUNITY OF COMPETITIVELY BID PRESCRIPTION DRUG CONTRACTS;

(C) PROCEDURES THAT AN MCO SHALL FOLLOW TO GIVE ALL PHARMACIES AND PHARMACY NETWORKS A FAIR OPPORTUNITY TO PARTICIPATE IN PRESCRIPTION DRUG CONTRACTS;

(D) ANY RELATED MATTERS THAT ARE DESIGNED TO EXPAND CONSUMER ACCESS TO PHARMACY SERVICES; AND

(E) ANY RELATED MATTERS THAT WILL ENHANCE THE FUNCTIONING OF THE FREE MARKET SYSTEM WITH RESPECT TO PHARMACIES.

(IV) NOTHING IN THIS PARAGRAPH (f) SHALL APPLY TO THE DELIVERY OF PRESCRIPTION DRUG BENEFITS TO RECIPIENTS ENROLLED IN AN MCO WHO ARE RESIDENTS OF A NURSING FACILITY.

(g) **Continuity of care.** (I) NEW ENROLLEES, WITH SPECIAL NEEDS AS DEFINED BY THE MEDICAL SERVICES BOARD AND AS CERTIFIED BY A NON-PLAN PHYSICIAN, MAY CONTINUE TO SEE A NON-PLAN PROVIDER FOR SIXTY DAYS FROM THE DATE OF ENROLLMENT IN AN MCO, IF THE ENROLLEE IS IN AN ONGOING COURSE OF TREATMENT WITH THE PREVIOUS PROVIDER AND ONLY IF THE PREVIOUS PROVIDER AGREES:

(A) TO ACCEPT REIMBURSEMENT FROM THE MCO AS PAYMENT IN FULL AT RATES ESTABLISHED BY THE MCO THAT SHALL BE NO MORE THAN THE LEVEL OF REIMBURSEMENT APPLICABLE TO SIMILAR PROVIDERS WITHIN THE MCO'S GROUP OR NETWORK FOR SUCH SERVICES;

(B) TO ADHERE TO THE MCO'S QUALITY ASSURANCE REQUIREMENTS AND TO PROVIDE TO THE MCO NECESSARY MEDICAL INFORMATION RELATED TO SUCH CARE; AND

(C) TO OTHERWISE ADHERE TO THE MCO'S POLICIES AND PROCEDURES INCLUDING BUT NOT LIMITED TO PROCEDURES REGARDING REFERRALS, OBTAINING PRE-AUTHORIZATIONS, AND MCO-APPROVED TREATMENT PLANS.

(II) NEW ENROLLEES WHO ARE IN THEIR SECOND OR THIRD TRIMESTER OF PREGNANCY MAY CONTINUE TO SEE THEIR PRACTITIONER UNTIL THE COMPLETION OF POST-PARTUM CARE DIRECTLY RELATED TO THE DELIVERY ONLY IF THE PRACTITIONER AGREES:

(A) TO ACCEPT REIMBURSEMENT FROM THE MCO AS PAYMENT IN FULL AT RATES ESTABLISHED BY THE MCO THAT SHALL BE NO MORE THAN THE LEVEL OF REIMBURSEMENT APPLICABLE TO SIMILAR PROVIDERS WITHIN THE MCO'S GROUP OR NETWORK FOR SUCH SERVICES;

(B) TO ADHERE TO THE MCO'S QUALITY ASSURANCE REQUIREMENTS AND TO PROVIDE TO THE MCO NECESSARY MEDICAL INFORMATION RELATED TO SUCH CARE; AND

(C) TO OTHERWISE ADHERE TO THE MCO'S POLICIES AND PROCEDURES INCLUDING BUT NOT LIMITED TO PROCEDURES REGARDING REFERRALS, OBTAINING PRE-AUTHORIZATIONS, AND MCO-APPROVED TREATMENT PLANS.

(III) NEW ENROLLEES WITH SPECIAL NEEDS AS DEFINED BY THE STATE DEPARTMENT MAY CONTINUE TO SEE ANCILLARY PROVIDERS AT THE LEVEL OF CARE RECEIVED PRIOR TO ENROLLMENT FOR A PERIOD OF UP TO SEVENTY-FIVE DAYS. THE TERMS AND CONDITIONS, INCLUDING REIMBURSEMENT RATES, SHALL REMAIN THE SAME AS PRIOR TO ENROLLMENT IF THE PROVIDER AND ENROLLEE AGREE TO WORK IN GOOD FAITH WITH THE MCO TOWARD A TRANSITION.

(IV) THIS PARAGRAPH (g) SHALL NOT BE CONSTRUED TO REQUIRE AN MCO TO PROVIDE COVERAGE FOR BENEFITS NOT OTHERWISE COVERED.

26-4-118. State department recommendations - primary care physician program - special needs - annual report. (1) (a) IT IS THE GENERAL ASSEMBLY'S INTENT THAT THE STATE OF COLORADO HAVE A STATEWIDE MANAGED CARE SYSTEM FOR MEDICAL ASSISTANCE RECIPIENTS WITH AT LEAST SEVENTY-FIVE PERCENT ENROLLMENT. THE GENERAL ASSEMBLY, HOWEVER, RECOGNIZES THE NEED FOR THE STATE DEPARTMENT TO EXPLORE VARIOUS METHODS OF PROVIDING MANAGED CARE FOR CERTAIN MEDICAL ASSISTANCE POPULATIONS. THE METHODS MAY RANGE FROM UNIQUE MANAGED CARE CONTRACTS WITH SPECIAL REIMBURSEMENT ARRANGEMENTS TO SPECIFIC PROVIDERS OR SERVICES. NO LATER THAN THE FIRST DAY OF DECEMBER OF EACH FISCAL YEAR OF THE IMPLEMENTATION PERIOD PROVIDED IN SECTION 26-4-113 (2), THE STATE DEPARTMENT SHALL MAKE RECOMMENDATIONS IN A WRITTEN REPORT TO THE GENERAL ASSEMBLY WITH RESPECT TO NECESSARY EXEMPTIONS FROM THE REQUIREMENT THAT MANAGED CARE BE IMPLEMENTED FOR SEVENTY-FIVE PERCENT OF THE MEDICAL ASSISTANCE POPULATION ON A STATEWIDE BASIS NO LATER THAN JULY 1, 2000.

(b) THE GENERAL ASSEMBLY RECOGNIZES THAT CAPITATED MANAGED CARE PROGRAMS MAY NOT BE APPROPRIATE FOR SOME SEGMENTS OF THE MEDICAID POPULATION. FOR EXAMPLE, RURAL MEDICAID RECIPIENTS MAY NOT HAVE A CHOICE OF CAPITATED MCO'S AND SPECIAL NEEDS POPULATIONS MAY NOT BE ABLE TO RECEIVE NECESSARY SERVICES FROM CAPITATED MCO'S.

(2) (a) THE PRIMARY CARE PHYSICIAN PROGRAM REQUIRES MEDICAID RECIPIENTS TO SELECT A PRIMARY CARE PHYSICIAN WHO IS SOLELY AUTHORIZED TO PROVIDE PRIMARY CARE AND REFERRAL TO ALL NECESSARY SPECIALTY SERVICES. TO ENCOURAGE LOW-COST AND ACCESSIBLE CARE, THE STATE DEPARTMENT IS AUTHORIZED TO UTILIZE THE PRIMARY CARE PHYSICIAN PROGRAM TO DELIVER SERVICES TO APPROPRIATE MEDICAID RECIPIENTS.

(b) THE STATE DEPARTMENT SHALL ESTABLISH PROCEDURES AND CRITERIA FOR THE COST-EFFECTIVE OPERATION OF THE PRIMARY CARE PHYSICIAN PROGRAM, INCLUDING BUT NOT LIMITED TO SUCH MATTERS AS APPROPRIATE ELIGIBILITY CRITERIA AND GEOGRAPHIC AREAS SERVED BY THE PROGRAMS.

26-4-119. Capitation rates - risk adjustments. (1) THE STATE DEPARTMENT SHALL MAKE PREPAID CAPITATION PAYMENT TO MANAGED CARE ORGANIZATIONS BASED UPON A DEFINED SCOPE OF SERVICES. PAYMENTS SHALL BE BASED UPON THE FOLLOWING UPPER AND LOWER LIMITS:

(a) THE UPPER LIMIT SHALL NOT EXCEED NINETY-FIVE PERCENT OF THE COST OF PROVIDING THESE SAME SERVICES ON AN ACTUARIALLY EQUIVALENT NON-MANAGED

CARE ENROLLED COLORADO MEDICAID POPULATION GROUP. THIS LIMIT MAY BE MODIFIED BASED UPON ANY FEDERAL REQUIREMENTS FOR REIMBURSEMENT TO FEDERALLY QUALIFIED HEALTH CLINICS AS DEFINED IN THE FEDERAL "SOCIAL SECURITY ACT".

(b) THE LOWER LIMIT SHALL BE A MARKET RATE SET THROUGH THE COMPETITIVE BID PROCESS FOR A SET OF DEFINED SERVICES. THE STATE DEPARTMENT SHALL ONLY USE MARKET RATE BIDS THAT DO NOT DISCRIMINATE AND ARE ADEQUATE TO ASSURE QUALITY, NETWORK SUFFICIENCY, AND LONG-TERM COMPETITIVENESS IN THE MEDICAID MANAGED CARE MARKET. A CERTIFICATION OF A QUALIFIED ACTUARY, RETAINED BY THE STATE DEPARTMENT, TO THE APPROPRIATE LOWER LIMIT SHALL BE CONCLUSIVE EVIDENCE OF THE STATE DEPARTMENT'S COMPLIANCE WITH THE REQUIREMENTS OF THIS PARAGRAPH (b). FOR THE PURPOSES OF THIS PARAGRAPH (b), A "QUALIFIED ACTUARY" SHALL BE A PERSON DEEMED AS SUCH UNDER REGULATIONS PROMULGATED BY THE COMMISSIONER OF INSURANCE.

(2) THE STATE DEPARTMENT SHALL DEVELOP CAPITATION RATES FOR MCO'S THAT INCLUDE RISK ADJUSTMENTS, REINSURANCE, OR STOP-LOSS FUNDING METHODS. PAYMENTS TO PLANS MAY VARY WHEN IT IS SHOWN THROUGH DIAGNOSES OR OTHER RELEVANT DATA THAT CERTAIN POPULATIONS ARE EXPECTED TO COST MORE OR LESS THAN THE CAPITATED POPULATION AS A WHOLE.

(3) THE MEDICAL SERVICES BOARD, IN CONSULTATION WITH RECOGNIZED MEDICAL AUTHORITIES, SHALL DEVELOP A DEFINITION OF SPECIAL NEEDS POPULATIONS THAT INCLUDES EVIDENCE OF DIAGNOSED OR MEDICALLY CONFIRMED HEALTH CONDITIONS. THE STATE DEPARTMENT SHALL DEVELOP A METHOD FOR ADJUSTING PAYMENTS TO PLANS FOR SUCH SPECIAL NEEDS POPULATIONS WHEN DIAGNOSES OR OTHER RELEVANT DATA INDICATES THESE SPECIAL NEEDS POPULATIONS WOULD COST SIGNIFICANTLY MORE THAN SIMILARLY CAPITATED POPULATIONS.

(4) THE RISK ADJUSTMENT, REINSURANCE, OR STOP-LOSS FUNDING METHODS DEVELOPED BY THE STATE DEPARTMENT PURSUANT TO SUBSECTION (2) OF THIS SECTION SHALL BE IMPLEMENTED NO LATER THAN JULY 1, 1998, ON THE CONDITION THAT THE DIAGNOSES AND RELEVANT DATA ARE MADE AVAILABLE TO THE STATE DEPARTMENT IN SUFFICIENT TIME TO ALLOW THE RATES TO BE SET BY JULY 1, 1998.

(5) UNDER NO CIRCUMSTANCES SHALL THE RISK ADJUSTMENTS, REINSURANCE, OR STOP-LOSS METHODS DEVELOPED BY THE STATE DEPARTMENT PURSUANT TO SUBSECTION (2) OF THIS SECTION CAUSE THE AVERAGE PER CAPITA MEDICAID PAYMENT TO A PLAN TO BE GREATER THAN THE PROJECTED MEDICAID EXPENDITURES FOR TREATING MEDICAID ENROLLEES OF THAT PLAN UNDER FEE-FOR-SERVICE MEDICAID.

(6) THE STATE DEPARTMENT MAY DEVELOP QUALITY INCENTIVE PAYMENTS TO RECOGNIZE SUPERIOR QUALITY OF CARE OR SERVICE PROVIDED BY A MANAGED CARE PLAN.

26-4-120. State department - privatization. (1) THE GENERAL ASSEMBLY FINDS THAT THE STATEWIDE MANAGED CARE SYSTEM IS A PROGRAM UNDER WHICH THE PRIVATE SECTOR HAS A GREAT DEAL OF EXPERIENCE IN MAKING VARIOUS HEALTH CARE PLANS AVAILABLE TO THE PRIVATE SECTOR AND SERVING AS THE LIAISON

BETWEEN LARGE EMPLOYERS AND HEALTH CARE PROVIDERS, INCLUDING BUT NOT LIMITED TO HEALTH MAINTENANCE ORGANIZATIONS. THE GENERAL ASSEMBLY THEREFORE DETERMINES THAT A STATEWIDE MANAGED CARE SYSTEM INVOLVES DUTIES SIMILAR TO DUTIES CURRENTLY OR PREVIOUSLY PERFORMED BY STATE EMPLOYEES BUT IS DIFFERENT IN SCOPE AND POLICY OBJECTIVES FROM THE STATE MEDICAL ASSISTANCE PROGRAM.

(2) TO THAT END, PURSUANT TO SECTION 24-50-504 (2) (a), C.R.S., THE STATE DEPARTMENT SHALL ENTER INTO PERSONAL SERVICES CONTRACTS THAT CREATE AN INDEPENDENT CONTRACTOR RELATIONSHIP FOR THE ADMINISTRATION OF NOT LESS THAN TWENTY PERCENT OF THE STATEWIDE MANAGED CARE SYSTEM. THE STATE DEPARTMENT SHALL ENTER INTO PERSONAL SERVICE CONTRACTS FOR THE ADMINISTRATION OF THE MANAGED CARE SYSTEM ACCORDING TO THE IMPLEMENTATION OF THE STATEWIDE MANAGED CARE SYSTEM IN ACCORDANCE WITH SECTION 26-4-113 (2).

(3) IN CONNECTION WITH THE REQUIREMENT SET FORTH IN SUBSECTION (2) OF THIS SECTION, THE STATE DEPARTMENT SHALL INCLUDE RECOMMENDATIONS CONCERNING PRIVATIZATION OF THE ADMINISTRATION OF THE MANAGED CARE SYSTEM IN ITS ANNUAL REPORT REQUIRED BY SECTION 26-4-118.

(4) THE IMPLEMENTATION OF THIS SECTION IS CONTINGENT UPON:

(a) LEGISLATIVE REVIEW OF THE COST-EFFECTIVENESS OF PRIVATIZATION AND THE EXTENT TO WHICH SUCH PRIVATIZATION ENHANCES THE QUALITY OF CARE TO RECIPIENTS; AND

(b) A FINDING BY THE STATE PERSONNEL DIRECTOR THAT ANY OF THE CONDITIONS OF SECTION 24-50-504 (2), C.R.S., HAVE BEEN MET OR THAT THE CONDITIONS OF SECTION 24-50-503 (1), C.R.S., HAVE BEEN MET.

26-4-121. Data collection for managed care programs - reports. (1) IN ADDITION TO ANY OTHER DATA COLLECTION OR REPORTING REQUIREMENTS SET FORTH IN THIS ARTICLE, THE STATE DEPARTMENT SHALL ACCESS AND COMPILE DATA CONCERNING HEALTH DATA AND OUTCOMES. IN ADDITION, NO LATER THAN JULY 1, 1998, THE STATE DEPARTMENT SHALL CONDUCT OR SHALL CONTRACT WITH AN INDEPENDENT EVALUATOR TO CONDUCT A QUALITY ASSURANCE ANALYSIS OF EACH MANAGED CARE PROGRAM IN THE STATE FOR MEDICAL ASSISTANCE RECIPIENTS. NO LATER THAN JULY 1, 1999, AND EACH FISCAL YEAR THEREAFTER, THE STATE DEPARTMENT, USING THE COMPILED DATA AND RESULTS FROM THE QUALITY ASSURANCE ANALYSIS, SHALL SUBMIT A REPORT TO THE HOUSE AND SENATE COMMITTEES ON HEALTH, ENVIRONMENT, WELFARE, AND INSTITUTIONS ON THE COST-EFFICIENCY OF EACH MANAGED CARE PROGRAM OR COMPONENT THEREOF, WITH RECOMMENDATIONS CONCERNING STATEWIDE IMPLEMENTATION OF THE RESPECTIVE PROGRAMS OR COMPONENTS. FOR THE PURPOSES OF THIS SUBSECTION (1), "QUALITY ASSURANCE" MEANS COSTS WEIGHED AGAINST BENEFITS PROVIDED TO CONSUMERS, HEALTH OUTCOMES OR MAINTENANCE OF THE INDIVIDUAL'S HIGHEST LEVEL OF FUNCTIONING, AND THE OVERALL CHANGE IN THE HEALTH STATUS OF THE POPULATION SERVED. THE STATE DEPARTMENT'S REPORT SHALL ADDRESS CAPITATION, INCLUDING METHODS FOR ADJUSTING RATES BASED ON RISK ALLOCATIONS, FEES-FOR-SERVICES, COPAYMENTS, CHRONICALLY ILL POPULATIONS, LONG-TERM CARE,

COMMUNITY-SUPPORTED SERVICES, AND THE ENTITLEMENT STATUS OF MEDICAL ASSISTANCE. THE STATE DEPARTMENT'S REPORT SHALL INCLUDE A COMPARISON OF THE EFFECTIVENESS OF THE MCO PROGRAM AND THE PRIMARY CARE PHYSICIAN PROGRAM BASED UPON COMMON PERFORMANCE STANDARDS THAT SHALL INCLUDE BUT NOT BE LIMITED TO RECIPIENT SATISFACTION.

(2) IN ADDITION, THE STATE DEPARTMENT OF HUMAN SERVICES, IN CONJUNCTION WITH THE STATE DEPARTMENT, SHALL CONTINUE ITS EXISTING EFFORTS, WHICH INCLUDE OBTAINING AND CONSIDERING CONSUMER INPUT, TO DEVELOP MANAGED CARE SYSTEMS FOR THE DEVELOPMENTALLY DISABLED POPULATION AND TO CONSIDER A PILOT PROGRAM FOR A CERTIFICATE SYSTEM TO ENABLE THE DEVELOPMENTALLY DISABLED POPULATION TO PURCHASE MANAGED CARE SERVICES OR FEE-FOR-SERVICE CARE, INCLUDING LONG-TERM CARE COMMUNITY SERVICES. THE DEPARTMENT OF HUMAN SERVICES SHALL NOT IMPLEMENT ANY MANAGED CARE SYSTEM FOR DEVELOPMENTALLY DISABLED SERVICES WITHOUT THE EXPRESS APPROVAL OF THE JOINT BUDGET COMMITTEE. ANY PROPOSED IMPLEMENTATION OF FULLY CAPITATED MANAGED CARE IN THE DEVELOPMENTAL DISABILITIES COMMUNITY SERVICE SYSTEM SHALL REQUIRE LEGISLATIVE REVIEW.

(3) IN ADDITION TO ANY OTHER DATA COLLECTION AND REPORTING REQUIREMENTS, EACH MANAGED CARE ORGANIZATION SHALL SUBMIT THE FOLLOWING TYPES OF DATA TO THE STATE DEPARTMENT OR ITS AGENT:

(a) MEDICAL ACCESS;

(b) CONSUMER OUTCOMES BASED ON STATISTICS MAINTAINED ON INDIVIDUAL CONSUMERS AS WELL AS THE TOTAL CONSUMER POPULATIONS SERVED;

(c) CONSUMER SATISFACTION;

(d) CONSUMER UTILIZATION;

(e) HEALTH STATUS OF CONSUMERS; AND

(f) UNCOMPENSATED CARE DELIVERED.

26-4-122. Integrated care and financing project. (1) THE STATE DEPARTMENT IS AUTHORIZED TO OVERSEE AND ADMINISTER THE INTEGRATED CARE AND FINANCING PROJECT TO STUDY THE INTEGRATION OF ACUTE AND LONG-TERM CARE WITHIN THE FOLLOWING GUIDELINES:

(a) THE PROJECT SHALL BE CONDUCTED IN A COUNTY OR COUNTIES SELECTED BY THE STATE DEPARTMENT THAT HAVE AT LEAST ONE YEAR'S EXPERIENCE IN PROVIDING MANAGED CARE FOR THE MEDICAL ASSISTANCE POPULATION AND HAS A SYSTEM FOR MANAGING LONG-TERM CARE, INCLUDING REFERRAL TO APPROPRIATE SERVICES, CASE PLANNING, AND BROKERING AND MONITORING OF SERVICES.

(b) THE STATE DEPARTMENT SHALL COMBINE ACUTE AND LONG-TERM CARE IN A MANAGED CARE ENVIRONMENT FOR THE PURPOSE OF CREATING COST-EFFICIENT AND ECONOMICAL CLINICAL APPROACHES TO SERVING THE MEDICAL ASSISTANCE POPULATION IN NEED OF BOTH TYPES OF CARE.

(c) THE STATE DEPARTMENT SHALL MAINTAIN APPLICABLE FEDERAL OR STATE ELIGIBILITY REQUIREMENTS.

(d) IN NO EVENT SHALL THE STATE DEPARTMENT REQUIRE ANY PERSON WHO IS ELIGIBLE FOR BOTH MEDICAL ASSISTANCE UNDER THE PROVISIONS OF THIS ARTICLE AND FOR ANOTHER THIRD-PARTY COVERAGE TO ENROLL IN AN MCO BEFORE JULY 1, 2000. NOTHING IN THIS PARAGRAPH (d) SHALL PREVENT THE STATE DEPARTMENT FROM PURCHASING THIRD-PARTY COVERAGE ON BEHALF OF A MEDICAID RECIPIENT.

(e) THE PROJECT SHALL BE FOR PERSONS ELIGIBLE FOR MEDICAL ASSISTANCE.

(f) PARTICIPANTS SHALL BE MEDICAL ASSISTANCE RECIPIENTS ENROLLED IN A HEALTH MAINTENANCE ORGANIZATION; EXCEPT THAT THE PROJECT SHALL NOT INCLUDE THE DELIVERY OF MENTAL HEALTH SERVICES AND DEVELOPMENTALLY DISABLED SERVICES, WHICH SERVICES SHALL CONTINUE TO BE PROVIDED THROUGH THE MENTAL HEALTH CAPITATION PROJECT AND THE DEVELOPMENTAL DISABILITIES SERVICES SYSTEM. PERSONS WITH DEVELOPMENTAL DISABILITIES AND MENTAL HEALTH NEEDS MAY PARTICIPATE IN THIS PROJECT FOR ALL THE SERVICES OFFERED BY THE PROJECT.

(g) THE PROJECT SHALL ADOPT GOALS THAT ENSURE: INTEGRATED ACUTE AND LONG-TERM MANAGED CARE RESULTS IN ADEQUATE ACCESS TO AND QUALITY OF HEALTH CARE; PARTICIPANT SATISFACTION AND IMPROVED PARTICIPANT HEALTH STATUS OR MAINTENANCE OF THE INDIVIDUAL'S HIGHEST LEVEL OF FUNCTIONING; AND SUFFICIENT COLLECTION OF HEALTH DATA AND PARTICIPANT OUTCOMES.

(h) THE STATE DEPARTMENT SHALL CONSULT WITH KNOWLEDGEABLE AND CONCERNED PERSONS IN THE STATE, INCLUDING CONSUMER ADVOCACY GROUPS, RECIPIENTS, AND CAREGIVERS.

(i) THE STATE MEDICAL SERVICES BOARD SHALL ADOPT RULES REQUIRING THE HEALTH MAINTENANCE ORGANIZATION TO ESTABLISH A COMPLAINT PROCESS FOR PARTICIPANTS DISSATISFIED WITH THE CARE PROVIDED UNDER THE PROJECT. IF A PARTICIPANT DISAGREES WITH THE ACTION TAKEN BY THE HEALTH MAINTENANCE ORGANIZATION, THE PARTICIPANT MAY SEEK REVIEW OF THE ACTION PURSUANT TO SECTION 25.5-1-107, C.R.S. IN ADDITION, THE STATE MEDICAL SERVICES BOARD SHALL ADOPT A PROCEDURE UNDER WHICH A PARTICIPANT MAY DISENROLL FROM THE PROJECT AND CONTINUE ELIGIBILITY UNDER THE MEDICAL ASSISTANCE PROGRAM.

(j) IN ADDITION TO USING OTHER METHODS OF MEASURING PARTICIPANT SATISFACTION AND OUTCOMES, THE STATE DEPARTMENT SHALL CONDUCT RANDOM SURVEYS TO ASSESS PARTICIPANT SATISFACTION AND MEET WITH RECIPIENT GROUPS BEING SERVED BY THE PROJECT.

(2) THE PROJECT MAY BE EXPANDED TO OTHER DEMONSTRATION SITES AND MAY BE MODIFIED IN ACCORDANCE WITH THE PROVISIONS OF THIS SECTION BASED UPON EXPERIENCE IN INITIAL DEMONSTRATION SITES, AS PERMITTED BY ANY NECESSARY FEDERAL WAIVERS, IN CONSULTATION WITH RELEVANT STAKEHOLDERS. THE STATE DEPARTMENT IS AUTHORIZED TO IMPLEMENT THIS PROJECT STATEWIDE ONLY AFTER FULL REVIEW BY THE GENERAL ASSEMBLY AND ONLY TO THE EXTENT THAT FEDERAL WAIVERS ARE RECEIVED.

26-4-123. Managed mental health services feasibility study - waiver - pilot program. [Formerly 26-4-528.] (1) ~~(a)~~ The STATE department ~~of health care policy and financing~~ and the department of human services shall jointly conduct a feasibility study concerning management of mental health services under the "Colorado Medical Assistance Act", which study shall consider a prepaid capitated system for providing comprehensive mental health services. In conducting the study, the STATE department ~~of health care policy and financing~~ and the department of human services shall:

~~(I)~~ (a) Consult with knowledgeable and concerned persons in the state, including low-income persons who are recipients of mental health services and providers of mental health services under the "Colorado Medical Assistance Act"; ~~and~~

~~(II)~~ (b) Consider the effect of any program on the provider or community mental health centers and clinics. Any prepaid capitated program shall, as much as possible, avoid exposing providers or community mental health centers and clinics to undue financial risk or reliance on supplemental revenues from state general funds, local revenues, or fee-for-service funds.

~~(b) Repealed.~~

(c) CONSIDER THE EFFECT OF ANY PROGRAM ON THE COORDINATION OF PATIENTS' MEDICAL CARE AND MENTAL HEALTH CARE AND ON PATIENTS' ACCESS TO PRESCRIPTION MEDICINES, INCLUDING MEDICINES FOR THE TREATMENT OF MENTAL DISORDERS.

(2) The state department is authorized to seek a waiver of the requirements of Title XIX of the social security act to allow the state department to limit a recipient's freedom of choice of providers and to restrict reimbursement for mental health services to designated and contracted agencies.

(3) (a) If a determination is made by the STATE department ~~of health care policy and financing~~ and the department of human services, based on the feasibility study required in subsection (1) of this section, that the implementation of one or more model or proposed program modifications would be cost-effective, and if all necessary federal waivers are obtained, the STATE department ~~of health care policy and financing~~ shall establish a pilot prepaid capitated system for providing comprehensive mental health services. The STATE department ~~of health care policy and financing~~ shall promulgate rules as necessary for the implementation and administration of the pilot program. The pilot program shall terminate on July 1, 1997. If the pilot program is implemented, the STATE department ~~of health care policy and financing~~ and the department of human services shall submit to the house and senate committees on health, environment, welfare, and institutions on or before July 1, 1996, a preliminary status report on the pilot program.

(b) In addition to the preliminary report described in paragraph (a) of this subsection (3), the STATE department ~~of health care policy and financing~~ and the department of human services shall submit a final report to the house and senate committees on health, environment, welfare, and institutions no later than January 1, 1997, addressing the following:

(I) An assessment of the pilot program costs, estimated cost-savings, benefits to recipients, recipient access to mental health services, and the impact of the program on recipients, providers, and the state mental health system;

(II) Recommendations concerning the feasibility of proceeding with a prepaid capitated system of comprehensive mental health services on a statewide basis;

(III) Recommendations resulting from consultation with local consumers, family members of recipients, providers of mental health services, and local human services agencies;

(IV) Recommendations concerning the role of community mental health centers under the prepaid capitated system, including plans to protect the integrity of the state mental health system and to ensure that community mental health providers are not exposed to undue financial risks under the prepaid capitated system. This subparagraph (IV) is based on the unique and historical role that community mental health centers have assumed in meeting the mental health needs of communities throughout the state.

~~(4) (Deleted by amendment, L. 95, p. 917, § 16, effective May 25, 1995.)~~

~~(5)~~ (4) The general assembly finds that preliminary indications from other states show that prepaid capitated systems for providing mental health services to medical assistance recipients result in cost-savings to the state. The general assembly therefore declares it appropriate to amend subsections ~~(1), (3), and (4)~~ (1) AND (3) of this section and to enact this subsection ~~(5)~~ (4) and subsections ~~(6) to (9)~~ (5) TO (8) of this section.

~~(6)~~ (5) On or before January 1, 1997, the STATE department ~~of health care policy and financing~~ shall seek the necessary waivers to implement the system statewide. No later than July 1, 1997, or ninety days after receipt of the necessary federal waivers, whichever occurs later, the department of human services, in cooperation with the STATE department, ~~of health care policy and financing,~~ shall begin to implement on a statewide basis a prepaid capitated system for providing comprehensive mental health services to recipients under the state medical assistance program. The prepaid capitated system shall be fully implemented no later than January 1, 1998, or six months after receipt of the necessary waivers, whichever occurs later. The waiver request shall be consistent with the report submitted to the general assembly in accordance with subsection (3) of this section.

~~(7)~~ (6) The STATE department, ~~of health care policy and financing,~~ in cooperation with the department of human services, shall revise the waiver request obtained pursuant to subsection (2) of this section or, if necessary, shall submit a new waiver request that allows the STATE department ~~of health care policy and financing~~ to limit a recipient's freedom of choice with respect to a provider of mental health services and to restrict reimbursements to mental health services providers. This waiver request or amendment shall be consolidated with the waiver described in subsection ~~(6)~~ (5) of this section.

~~(8)~~ (7) No later than May 1, 1997, or sixty days after receipt of the necessary federal waivers described in subsections ~~(6) and (7)~~ (5) AND (6) of this section,

whichever occurs later, the executive director of the STATE department ~~of health care policy and financing~~ shall propose rules to the medical services board for the implementation of the prepaid capitated single entry point system for mental health services.

~~(9)~~ (8) The implementation of this subsection ~~(9)~~ (8) and subsections ~~(5) to (8)~~ (4) TO (7) of this section is conditioned upon the receipt of necessary federal waivers. The implementation of the statewide system shall conform to the provisions of the federal waiver; except that, no later than ninety days after receipt of the federal waivers, the STATE department ~~of health care policy and financing~~ shall submit to the general assembly a report that outlines the provisions of the waiver and makes recommendations for legislation during the next legislative session that assures state conformance to the federal waivers.

26-4-124. Program of all-inclusive care for the elderly - services - eligibility. [Formerly 26-4-519.] (1) The general assembly hereby finds and declares that it is the intent of this section to replicate the ON LOK program in San Francisco, California, that has proven to be cost-effective at both the state and federal levels. The PACE program is part of a national replication project authorized in section 9412(b)(2) of the federal "Omnibus Budget Reconciliation Act of 1986", as amended, which instructs the secretary of the federal department of health and human services to grant medicare and medicaid waivers to permit not more than ten public or nonprofit private community-based organizations in the country to provide comprehensive health care services on a capitated basis to frail elderly who are at risk of institutionalization. The general assembly finds that, by coordinating an extensive array of medical and nonmedical services, the needs of the participants will be met primarily in an outpatient environment in an adult day health center, in their homes, or in an institutional setting. The general assembly finds that such a service delivery system will enhance the quality of life for the participant and offers the potential to reduce and cap the costs to Colorado of the medical needs of the participants, including hospital and nursing home admissions.

~~(1.5)~~ (2) The general assembly has determined on the recommendation of the state department ~~of health care policy and financing~~ that the PACE program is cost-effective. As a result of such determination and after consultation with the joint budget committee of the general assembly, application has been made to and waivers have been obtained from the federal health care financing administration to implement the PACE program as provided in this section. The general assembly, therefore, authorizes the state department to implement the PACE program in accordance with this section. In connection with the implementation of the program, the state department shall:

(a) Provide a system for reimbursement for services to the PACE program pursuant to this section;

(b) Develop and implement a contract with the nonprofit organization providing the PACE program that sets forth contractual obligations for the PACE program, including but not limited to reporting and monitoring of utilization of services and of the costs of the program as required by the state department;

(c) Acknowledge that it is participating in the national PACE project as initiated

by congress;

(d) Be responsible for certifying the eligibility for services of all PACE program participants.

~~(2)~~ (3) The general assembly declares that the purpose of this section is to provide services ~~which~~ THAT would foster the following goals:

(a) To maintain eligible persons at home as an alternative to long-term institutionalization;

(b) To provide optimum accessibility to various important social and health resources that are available to assist eligible persons in maintaining independent living;

(c) To provide that eligible persons who are frail elderly but who have the capacity to remain in an independent living situation have access to the appropriate social and health services without which independent living would not be possible;

(d) To coordinate, integrate, and link such social and health services by removing obstacles ~~which~~ THAT impede or limit improvements in delivery of these services;

(e) To provide the most efficient and effective use of capitated funds in the delivery of such social and health services;

(f) To assure that capitation payments amount to no more than ninety-five percent of the amount paid under the medicaid fee-for-service structure for an actuarially similar population.

~~(3)~~ (4) Within the context of the PACE program, the state department may include any or all of the services listed in sections 26-4-202, 26-4-203, 26-4-302, and 26-4-303, as applicable.

~~(4)~~ (5) An eligible person may elect to receive services from the PACE program as described in subsection ~~(3)~~ (4) of this section. If such an election is made, the eligible person shall not remain eligible for services or payment through the regular medicare or medicaid programs. All services provided by said programs shall be provided through the PACE program in accordance with this section. An eligible person may elect to disenroll from the PACE program at any time.

~~(5)~~ (6) For purposes of this section, "eligible person" means a frail elderly individual who voluntarily enrolls in the PACE program and whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, whose resources do not exceed the limit established by the state department of human services for individuals receiving a mandatory minimum state supplementation of SSI benefits pursuant to section 26-2-204, and for whom a physician licensed pursuant to article 36 of title 12, C.R.S., certifies that such a program provides an appropriate alternative to institutionalized care. The term "frail elderly" means an individual who meets functional eligibility requirements, as established by the state department, for nursing home care and who is sixty-five years of age or older.

~~(6)~~ (7) Using a risk-based financing model, the nonprofit organization providing the PACE program shall assume responsibility for all costs generated by PACE program participants, and it shall create and maintain a risk reserve fund that will cover any cost overages for any participant. The PACE program is responsible for the entire range of services in the consolidated service model, including hospital and nursing home care, according to participant need as determined by the multidisciplinary team. The nonprofit organization providing the PACE program is responsible for the full financial risk at the conclusion of the demonstration period and when permanent waivers from the federal health care financing administration are granted. Specific arrangements of the risk-based financing model shall be adopted and negotiated by the federal health care financing administration, the nonprofit organization providing the PACE program, and the state department.

~~(7) (Deleted by amendment, L. 95, p. 912, § 10, effective May 25, 1995.)~~

(8) Any person who accepts and receives services authorized under this section shall pay to the state department or to an agent or provider designated by the state department an amount that shall be the lesser of such person's gross income minus the current federal aid to needy disabled supplemental security income benefit level and cost of dependents and minus any amounts paid for private health or medical insurance, or the projected cost of services to be rendered to the person under the plan of care. Such amount shall be reviewed and revised as necessary each time the plan of care is reviewed. The state department shall establish a standard amount to be allowed for the costs of dependents. In determining a person's gross income, the state department shall establish, by rule, a deduction schedule to be allowed and applied in the case of any person who has incurred excessive medical expenses or other outstanding liabilities that require payments.

~~(9) (Deleted by amendment, L. 95, p. 912, § 10, effective May 25, 1995.)~~

~~(10)~~ (9) The medical services board shall promulgate such rules and regulations, pursuant to article 4 of title 24, C.R.S., as are necessary to implement this section.

~~(11)~~ (10) The general assembly shall make appropriations to the state department ~~of health care policy and financing~~ to fund services under this section provided at a monthly capitated rate. The state department ~~of health care policy and financing~~ shall annually renegotiate a monthly capitated rate for the contracted services based on the ninety-five percent of the medicaid fee-for-service costs of an actuarially similar population.

~~(12)~~ (11) The state department may accept grants and donations from private sources for the purpose of implementing this section.

~~(13) (Deleted by amendment, L. 95, p. 912, § 10, effective May 25, 1995.)~~

26-4-125. Study of certificate program - provider-sponsored organizations. (1) NO LATER THAN JANUARY 1, 1998, THE STATE DEPARTMENT SHALL SUBMIT TO THE GENERAL ASSEMBLY A LIST OF OPTIONS FOR THE STATE AND THE STATE DEPARTMENT'S RECOMMENDATIONS FOR THE IMPLEMENTATION OF A CONSUMER CERTIFICATE CHOICE PROGRAM. IN CONNECTION WITH THIS SUBMISSION, THE STATE DEPARTMENT SHALL CONSIDER PROCEDURES FOR THE FOLLOWING ACTIVITIES:

(a) SETTING THE VALUE OF A CERTIFICATE;

(b) CONTROLLING THE USE OF A CERTIFICATE;

(c) ESTABLISHING A COMPETITIVE BIDDING PROCESS FOR MCO'S AND HEALTH BENEFIT PLANS THAT WILL PARTICIPATE IN A CONSUMER CERTIFICATE CHOICE PROGRAM;

(d) ESTABLISHING WHERE THE RISK IS ASSUMED IN THE EVENT THAT A CONSUMER EXHAUSTS THE TOTAL VALUE OF A CERTIFICATE ALLOWANCE AND IS STILL IN NEED OF SERVICES;

(e) ASSESSING QUALITY OUTCOMES FOR A CONSUMER CERTIFICATE CHOICE PROGRAM;

(f) COLLECTING DATA AND OUTCOME MEASUREMENTS;

(g) EDUCATING CLIENTS ABOUT CHOICE AND USE OF CERTIFICATES.

(2) THE STATE DEPARTMENT SHALL ALSO INCLUDE RECOMMENDATIONS AS TO INCLUSION OF THE MEDICALLY INDIGENT POPULATION IN THE CONSUMER CERTIFICATE CHOICE PROGRAM. EXPANDED COVERAGE TO IMPOVERISHED COLORADANS SHOULD BE DEVELOPED BASED UPON AN ASSESSMENT OF HOW THE STATE CAN MAKE THE MOST EFFICIENT USE OF ALL PUBLIC MONEYS INCLUDING, BUT NOT LIMITED TO, MEDICAID, MEDICALLY INDIGENT, AND DISPROPORTIONATE SHARE FUNDS. THE STATE DEPARTMENT SHALL ALSO EXAMINE ALTERNATIVE SUBSIDY STRUCTURES AND FUNDING RESOURCES FOR THE CONSUMER CERTIFICATE CHOICE PROGRAM.

(3) FOR PURPOSES OF THIS SECTION, "HEALTH BENEFIT PLAN" MEANS ANY HOSPITAL OR MEDICAL EXPENSE POLICY OR CERTIFICATE, HOSPITAL OR MEDICAL SERVICE CORPORATION CONTRACT, OR HEALTH MAINTENANCE ORGANIZATION SUBSCRIBER CONTRACT.

(4) THE STATE DEPARTMENT, IN CONSULTATION WITH THE COMMISSIONER OF INSURANCE, IS ENCOURAGED TO REVIEW THE POTENTIAL FOR MEDICAID SAVINGS THROUGH DIRECT CONTRACTING WITH PROVIDER-SPONSORED ORGANIZATIONS.

26-4-126 to 26-4-130. (Reserved)

SECTION 4. 25.5-1-401, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

25.5-1-401. Health care coverage cooperatives - rule-making authority. The executive director may promulgate rules and regulations consistent with the provisions of sections 6-18-204, 6-18-206, 6-18-207, 6-18-207.5, and 6-18-207.7, C.R.S., for purposes of carrying out the executive director's duties under said sections. The executive director may promulgate rules and regulations to carry out the executive director's duties under section 6-18-202, C.R.S., so long as such rules and regulations add no additional requirements other than those specifically enumerated in said section 6-18-202, C.R.S.; EXCEPT THAT THE EXECUTIVE DIRECTOR MAY ADOPT ADDITIONAL RULES AND REGULATIONS PURSUANT TO SUBPART 2 OF PART

1 OF ARTICLE 4 OF TITLE 26, C.R.S.

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

26-4-404. Providers - payments - rules. (4) (c) The state department shall ensure the following:

(I) ~~A managed care provider shall allow a recipient to disenroll at any time;~~

(II) A managed care provider shall establish and implement consumer friendly procedures and instructions for disenrollment and shall have adequate staff to explain issues concerning service delivery and disenrollment procedures to recipients, including staff to address the communications needs and requirements of recipients with disabilities.

(III) All recipients shall be adequately informed about service delivery options available to them consistent with the provisions of this subparagraph (III). If a recipient does not respond to a state department request for selection of a delivery option within forty-five calendar days, the state department shall send a second notification to the recipient. If the recipient does not respond within twenty days of the date of the second notification, the state department shall ensure that the recipient remains with the recipient's primary care physician, regardless of whether said primary care physician is enrolled in a health maintenance organization.

SECTION 6. 26-4-303 (1) (h), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

26-4-303. Optional programs with special state provisions. (1) This section specifies programs developed by Colorado to increase federal financial participation through selecting optional services or optional eligible groups. These programs include but are not limited to:

(h) The program of all-inclusive care for the elderly, as specified in section ~~26-4-519~~ 26-4-124;

SECTION 7. 26-4-404 (1) (b) (II), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

26-4-404. Providers - payments - rules. (1) (b) (II) The general assembly shall annually appropriate to the state department of health care policy and financing one-half of the amount that would have been paid to providers if the services described in subparagraph (I) of this paragraph (b) were compensated under both Title XIX and Title XVIII of the social security act, which shall be applied to the ~~costs and expenses of any primary care provider incentive program established as a part of any managed care system established pursuant to section 26-4-104 (2)~~ MAINTENANCE OF A FIXED MARKET RATE PRIMARY CARE PROVIDER INCENTIVE PAYMENT. ANY BALANCE IN THE SAVINGS MAY BE USED TO COVER THE ADMINISTRATIVE COSTS OF IMPLEMENTING MANAGED CARE PURSUANT TO THE PROVISIONS OF SUBPART 2 OF PART 1 OF THIS ARTICLE AND THE COSTS OF THE EXPANSION OF THE INCENTIVE PROGRAM TO PROVIDERS OF DENTAL SERVICES FOR

CHILDREN UNDER THE EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT PROGRAM.

SECTION 8. 26-4-301.3 (1), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

26-4-301.3. Managed care programs - guaranteed minimum enrollment for recipients who become ineligible for benefits - optional program. (1) Beginning January 1, 1995, any recipient who becomes ineligible to receive benefits under this article ~~and who has been enrolled in a managed care program for less than six months~~ shall continue to be eligible for enrollment in such program for the minimum enrollment period IF THE RECIPIENT:

(a) HAS SELECTED OR BEEN ASSIGNED TO A FEDERALLY QUALIFIED HEALTH MAINTENANCE ORGANIZATION OR PREPAID HEALTH PLAN WITHIN NINETY DAYS OF BECOMING ELIGIBLE FOR MEDICAID; AND

(b) HAS BEEN ENROLLED IN THE MANAGED CARE PROGRAM FOR LESS THAN SIX MONTHS.

SECTION 9. Repeal of provisions being relocated in this act. Sections 26-4-519 and 26-4-528, Colorado Revised Statutes, 1989 Repl. Vol., as amended, are repealed.

SECTION 10. Appropriations in long bill to be adjusted. For the implementation of this act, appropriations made in the annual general appropriation act for the fiscal year beginning July 1, 1997, to the department of health care policy and financing, shall be adjusted as follows:

(1) The appropriation to medical programs, administration is increased by three hundred thirty-eight thousand five hundred thirty-four dollars ($338,534), and 4.0 FTE. Of said sum, one hundred sixty-nine thousand two hundred sixty-seven dollars ($169,267) shall be from the general fund and one hundred sixty-nine thousand two hundred sixty-seven dollars ($169,267) shall be from matching federal funds. Said sum shall be for managed care plan oversight pursuant to section 26-4-113, Colorado Revised Statutes.

(2) The appropriation to medical programs, administration is increased by one million eighteen thousand one hundred twenty-four dollars ($1,018,124), and 3.0 FTE. Of said sum, three hundred eighty-five thousand eight hundred sixty dollars ($385,860) shall be from the general fund and subject to the "(M)" notation as defined in the general appropriation act and six hundred thirty-two thousand two hundred sixty-four dollars ($632,264) shall be from matching federal funds. Said sum shall be for quality assurance and client grievance procedures pursuant to sections 26-4-115, 26-4-116 (1), 26-4-120 (3), and 26-4-117 (1) (b), Colorado Revised Statutes.

(3) The appropriation to medical programs, administration is increased by one million eight hundred eighty thousand eighty-eight dollars ($1,880,088), and 1.0 FTE. Of said sum, nine hundred forty thousand forty-four dollars ($940,044) shall be from the general fund and subject to the "(M)" notation as defined in the general

appropriation act and nine hundred forty thousand forty-four dollars ($940,044) shall be from matching federal funds. Said sum shall be for the enrollment broker function pursuant to section 26-4-117 (1) (a) (II), Colorado Revised Statutes.

(4) The appropriation to medical programs, medical services is decreased by two million four hundred seventy-one thousand seven hundred eight dollars ($2,471,708). Of said sum, one million one hundred eighty-five thousand six hundred seventy-eight dollars ($1,185,678) shall be from the general fund and one million two hundred eighty-six thousand thirty dollars ($1,286,030) shall be from matching federal funds. Said sum shall be from net savings associated with moving clients into managed care, pursuant to section 26-4-113, Colorado Revised Statutes.

(5) The appropriation to medical programs, other medical services, physician incentive pool is decreased by one million four hundred thirty-one thousand two hundred thirty-six dollars ($1,431,236). Of said sum, six hundred seventy-eight thousand four hundred forty-three dollars ($678,443) shall be from the general fund and seven hundred fifty-two thousand seven hundred ninety-three dollars ($752,793) shall be from federal funds. Said sum shall be from savings associated with the movement to a fixed market rate primary care provider incentive payment, pursuant to section 26-4-404 (1) (b) (II), Colorado Revised Statutes.

SECTION 11. 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, 1997