

## CHAPTER 225

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**HEALTH CARE POLICY AND FINANCING**

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**HOUSE BILL 02-1292**

BY REPRESENTATIVE(S) Clapp, Boyd, Coleman, Crane, Hefley, Jahn, Mace, Stafford, Tochtrop, Weddig, Williams S., and Young;  
also SENATOR(S) Reeves, Hanna, Linkhart, and Owen.

**AN ACT**

**CONCERNING THE STATEWIDE MANAGED CARE SYSTEM UNDER THE "COLORADO MEDICAL ASSISTANCE ACT", AND MAKING AN APPROPRIATION IN CONNECTION THEREWITH.**

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

**SECTION 1. Repeal.** 26-4-112, Colorado Revised Statutes, is repealed as follows:

**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) (1) 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~~

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

may be impractical for Colorado:

~~(H) 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, as it existed prior to June 1, 1999, as amended, 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.~~

**SECTION 2.** 26-4-113, Colorado Revised Statutes, is amended to read:

**26-4-113. Statewide managed care system.** (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~~ CLIENTS pursuant to the provisions of this article. THE STATEWIDE MANAGED CARE SYSTEM SHALL BE IMPLEMENTED TO THE EXTENT POSSIBLE. ~~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; except in those counties in which there is a written agreement between the county department of social services, the designated and contracted mental health assessment and services agency selected pursuant to section 26-4-123, and the state department. 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, and health care coverage cooperatives in eliminating unnecessary and unrelated rules and functions.~~

(1.5) THE MANAGED CARE SYSTEM IMPLEMENTED PURSUANT TO THIS ARTICLE SHALL NOT INCLUDE:

(a) THE SERVICES DELIVERED UNDER THE RESIDENTIAL CHILD HEALTH CARE PROGRAM DESCRIBED IN SECTION 26-4-527, EXCEPT IN THOSE COUNTIES IN WHICH THERE IS A WRITTEN AGREEMENT BETWEEN THE COUNTY DEPARTMENT OF SOCIAL SERVICES, THE DESIGNATED AND CONTRACTED MENTAL HEALTH ASSESSMENT AND SERVICES AGENCY SELECTED PURSUANT TO SECTION 26-4-123, AND THE STATE DEPARTMENT.

(b) LONG-TERM CARE SERVICES, EXCEPT FOR THE INTEGRATED CARE AND FINANCING PROJECT, AS DESCRIBED IN SECTION 26-4-122, AND THE PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY, AS DESCRIBED IN SECTION 26-4-124. FOR PURPOSES OF THIS SUBSECTION (1.5), "LONG-TERM CARE SERVICES" MEANS NURSING FACILITIES AND HOME- AND COMMUNITY-BASED SERVICES PROVIDED TO ELIGIBLE CLIENTS WHO HAVE BEEN DETERMINED TO BE IN NEED OF SUCH SERVICES PURSUANT TO THE "COLORADO MEDICAL ASSISTANCE ACT" AND THE STATE DEPARTMENT'S RULES.

(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;~~

~~(IV) **Elderly.** Program of all-inclusive care for the elderly, as described in section 26-4-124.~~

(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~~ MANAGED CARE ORGANIZATIONS SEEKING TO PROVIDE medical services ~~on a managed care basis~~ for ~~persons~~ MEDICAID CLIENTS eligible to be enrolled in managed care. The state department is authorized to award contracts to more than one offeror. The state department procedures shall seek to use competitive bidding procedures to maximize the number of managed care choices available to medicaid clients over the long term that meet the requirements of sections 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 GRADUATE MEDICAL EDUCATION, REFERRED TO IN THIS SUBSECTION (6) AS "GME"**, funding to teaching hospitals that have graduate medical education expenses in their medicare cost report and are participating as providers under one or more MCO 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 October 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 children's basic health plan created in article 19 of this title has reduced providers' uncompensated burdens and an assessment of changes on the financial viability of essential community providers.~~

~~(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. The general assembly may appropriate savings achieved through~~

~~implementation of this subpart 2 and described in this subsection (7) to cover the costs of the program provided in subsection (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 waived optional program described in subsection (9) of this section.~~

~~(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 subsection (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 program described in subsection (9) of this section.~~

~~(f) (Deleted by amendment, L. 2000, p. 2011, § 14, effective June 3, 2000.)~~

~~(8) (Deleted by amendment, L. 2000, p. 2011, § 14, effective June 3, 2000.)~~

~~(9) **Grants programs.** (a) Subject to appropriations as described in paragraph (e) 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) Repealed.~~

**SECTION 3.** 26-4-114, Colorado Revised Statutes, is amended to read:

**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", REFERRED TO IN THIS SUBPART 2 AS AN "MCO", means an entity contracting with the state department that provides, delivers, arranges for, pays for, or reimburses any of the costs of health care services through the recipient's use of health care providers managed by, owned by, under contract with, or employed by the entity because the entity or the state department either requires the recipient's use of those providers or creates incentives, including financial incentives, for the recipient's use of those providers.

(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.

**SECTION 4.** 26-4-115, Colorado Revised Statutes, is amended to read:

**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~~ IN ADDITION TO ANY OTHER CRITERIA SPECIFIED IN RULE BY THE MEDICAL SERVICES BOARD, IN ORDER to participate in the statewide managed care system, ~~based upon the MCO's assurance and the state department's verification of compliance~~ THE MCO SHALL COMPLY 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~~ SHALL not interfere with appropriate medical care decisions rendered by the provider nor penalize the provider for requesting medical services outside the standard treatment protocols developed by the MCO or its contractors;

(b) The MCO ~~will~~ SHALL 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) THE MCO SHALL HAVE an educational component in ~~the MCO's~~ ITS 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) THE MCO SHALL PROVIDE THE minimum benefit requirements as established by the medical services board;

(e) ~~Provision of~~ THE MCO SHALL PROVIDE necessary and appropriate services to recipients that shall include but not be limited to the following:

(I) With respect to recipients who are unable to make decisions for themselves, ~~collaboration by~~ the MCO and all relevant providers in the MCO's network serving the recipients SHALL COLLABORATE with the designated advocate or family member in all decision-making including enrollment and disenrollment;

(II) ~~Delivery of~~ THE MCO SHALL DELIVER services that are covered benefits in a manner that accommodates or is compatible with the recipient's ability to fulfill duties and responsibilities in work and community activities;

(f) THE MCO SHALL PROVIDE appropriate use of ancillary health care providers by appropriate qualified health care professionals;

(g) THE MCO SHALL COMPLY WITH ALL data collection and reporting requirements established by the ~~medical services board~~ STATE DEPARTMENT;

(h) THE MCO SHALL, to the extent provided by law or waiver, ~~provision of~~ PROVIDE 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) THE MCO SHALL COMPLY WITH utilization requirements established by the state department;

(j) THE MCO SHALL DEVELOP AND UTILIZE a form or process for measuring group and individual recipient health outcomes, including but not limited to the use of tools or methods that identify increased health status or maintenance of the individual's highest level of functioning, determine the degree of medical access, and reveal recipient satisfaction and habits. Such tools shall include the use of client surveys, anecdotal information, complaint and grievance data, and disenrollment information. The MCO 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) EXCEPT AS PROVIDED FOR IN PARAGRAPH (k.2) OF THIS SUBSECTION (2), FOR CAPITATION PAYMENTS EFFECTIVE ON AND AFTER JULY 1, 2003, THE MCO SHALL CERTIFY THE financial stability of the MCO PURSUANT TO CRITERIA ESTABLISHED BY

THE DIVISION OF INSURANCE AND SHALL CERTIFY, AS A CONDITION OF ENTERING INTO A CONTRACT WITH THE STATE DEPARTMENT, THAT THE CAPITATION PAYMENTS SET FORTH IN THE CONTRACT BETWEEN THE MCO AND THE STATE DEPARTMENT ARE SUFFICIENT TO ASSURE THE FINANCIAL STABILITY OF THE MCO WITH RESPECT TO DELIVERY OF SERVICES TO THE MEDICAID RECIPIENTS COVERED IN THE CONTRACT;

(k.1) EXCEPT AS PROVIDED FOR IN PARAGRAPH (k.2) OF THIS SUBSECTION (2), FOR CAPITATION PAYMENTS EFFECTIVE ON AND AFTER JULY 1, 2003, THE MCO SHALL CERTIFY, THROUGH A QUALIFIED ACTUARY RETAINED BY THE MCO, THAT THE CAPITATION PAYMENTS SET FORTH IN THE CONTRACT BETWEEN THE MCO AND THE STATE DEPARTMENT COMPLY WITH ALL APPLICABLE FEDERAL AND STATE REQUIREMENTS THAT GOVERN SAID CAPITATION PAYMENTS. FOR PURPOSES OF THIS PARAGRAPH (k.1), A "QUALIFIED ACTUARY" MEANS A PERSON DEEMED AS SUCH BY RULE PROMULGATED BY THE COMMISSIONER OF INSURANCE.

(k.2) AN MCO PROVIDING SERVICES UNDER THE PACE PROGRAM AS DESCRIBED IN SECTION 26-4-124 SHALL CERTIFY THAT THE CAPITATION PAYMENTS ARE IN COMPLIANCE WITH APPLICABLE FEDERAL AND STATE REQUIREMENTS THAT GOVERN SAID CAPITATION PAYMENTS AND THAT THE CAPITATION PAYMENTS ARE SUFFICIENT TO ASSURE THE FINANCIAL VIABILITY OF THE MCO WITH RESPECT TO THE DELIVERY OF SERVICES TO THE PACE PROGRAM PARTICIPANTS COVERED IN THE CONTRACT.

(l) THE MCO SHALL PROVIDE 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) THE MCO HAS ESTABLISHED 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~~ THE MCO SHALL NOTIFY ALL RECIPIENTS INVOLVED IN A DISPUTE WITH THE MCO OF THEIR RIGHT TO seek an administrative review of an adverse decision made by the MCO PURSUANT TO SECTION 25.5-1-107, C.R.S.

(n) With respect to pregnant women and infants, the MCO SHALL COMPLY WITH 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~~ SHALL accept all enrollees regardless of health status; ~~consistent with the provisions of section 26-4-118;~~

(p) THE MCO SHALL COMPLY WITH disclosure requirements as established by the state department and THE medical services board;

(q) THE MCO SHALL provide a mechanism whereby a prescribing physician can request to override restrictions to obtain medically necessary off-formulary prescription drugs, supplies, equipment, or services for his or her patient;

(r) ~~Maintenance of~~ THE MCO SHALL MAINTAIN 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.

(7) NOTHING IN THIS SUBPART 2 SHALL BE CONSTRUED TO CREATE AN ENTITLEMENT TO AN MCO TO CONTRACT WITH THE STATE DEPARTMENT.

**SECTION 5.** 26-4-117 (1) (a) and (1) (b), Colorado Revised Statutes, are amended to read:

**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 MCO'S SHALL PROVIDE ENROLLEES a choice among providers within an~~ THE 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) THE STATE DEPARTMENT DETERMINES THAT 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~~ THIRTY 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~~ THE STATE DEPARTMENT SHALL INFORM RECIPIENTS of the choices available in their area by appropriate sources of information and counseling. This ~~shall~~ MAY include an independent, objective facilitator acting under the supervision of the state department. The state department ~~shall~~ MAY contract for the facilitator through a competitive bidding process. This function shall ensure that consumers have informed choice among available options to assure the fullest possible voluntary participation in managed care. ~~The facilitator shall attempt to collect and~~ THE STATE DEPARTMENT SHALL 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 STATE 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 twelve months; except that the recipient may disenroll without good cause during the first ninety days of enrollment or any time thereafter for good cause as determined by the state department. Good cause shall include but need not be limited to administrative error and an MCO's 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 STATE DEPARTMENT SHALL ESTABLISH THE POSITION OF OMBUDSMAN FOR MEDICAID MANAGED CARE. IT IS THE INTENT OF THE GENERAL ASSEMBLY THAT THE OMBUDSMAN FOR MEDICAID MANAGED CARE BE INDEPENDENT FROM THE STATE DEPARTMENT AND SELECTED THROUGH A COMPETITIVE BIDDING PROCESS. IN THE EVENT THE STATE DEPARTMENT IS UNABLE TO CONTRACT WITH AN INDEPENDENT OMBUDSMAN, AN EMPLOYEE OF THE STATE DEPARTMENT MAY SERVE AS THE OMBUDSMAN FOR MEDICAID MANAGED CARE. THE OMBUDSMAN SHALL, IF THE ENROLLEE REQUESTS, ACT AS THE ENROLLEE'S REPRESENTATIVE IN RESOLVING COMPLAINTS AND GRIEVANCES WITH THE MCO. 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);~~ THE OMBUDSMAN FOR MEDICAID MANAGED CARE, a lay advocate, or the enrollee's physician, to file and pursue a grievance or expedited review on behalf of the enrollee. The procedure shall allow for the unencumbered participation of physicians. An enrollee whose complaint or grievance is not resolved to his or her satisfaction by a procedure described in this paragraph (b) or who chooses to forego a procedure described in this paragraph (b) shall be entitled to request a second-level review by an independent hearing officer, further judicial review, or both, as provided for by federal law and any state statute or regulation. The state department may also provide by regulation for arbitration as an optional alternative to the complaint and grievance procedure set forth in this paragraph (b) to the extent that such regulations do not violate any other state or federal statutory or constitutional requirements.

**SECTION 6. Repeal.** 26-4-118 (1), Colorado Revised Statutes, is repealed as follows:

**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 capitate MCO's.~~

**SECTION 7.** 26-4-119 (1) and (4), Colorado Revised Statutes, are amended, and the said 26-4-119 is further amended BY THE ADDITION OF THE FOLLOWING NEW SUBSECTIONS, to read:

**26-4-119. Capitation payments - availability of base data - adjustments - rate calculation - capitation payment proposal - preference - assignment of medicaid recipients.** (1) (a) The state department shall make prepaid capitation payment to managed care organizations based upon a defined scope of services. ~~Payments shall be based upon the following upper and lower limits:~~

~~(a) (b) Except as otherwise provided in paragraph (e) (d) of this subsection (1), the upper limit shall not exceed~~ UNDER NO CIRCUMSTANCES, INCLUDING COMPETITIVE BIDDING AS SET FORTH IN PARAGRAPH (c) OF THIS SUBSECTION (1), SHALL THE STATE DEPARTMENT PAY A CAPITATION PAYMENT TO AN MCO THAT EXCEEDS ninety-five percent of the DIRECT HEALTH CARE cost of providing these same services on an actuarially equivalent ~~non-managed care-enrolled~~ Colorado medicaid population group CONSISTING OF UNASSIGNED RECIPIENTS AND RECIPIENTS IN THE PRIMARY CARE PHYSICIAN PROGRAM PROVIDED IN SECTION 26-4-118. A CERTIFICATION BY A QUALIFIED ACTUARY RETAINED BY THE STATE DEPARTMENT SHALL BE CONCLUSIVE EVIDENCE THAT THE STATE DEPARTMENT HAS CORRECTLY CALCULATED THE DIRECT HEALTH CARE COST OF PROVIDING THESE SAME SERVICES ON AN ACTUARIALLY EQUIVALENT COLORADO MEDICAID POPULATION GROUP CONSISTING OF UNASSIGNED RECIPIENTS AND RECIPIENTS IN THE PRIMARY CARE PHYSICIAN PROGRAM PROVIDED IN SECTION 26-4-118.

~~(b) (c) Except as otherwise provided in paragraph (e) (d) of this subsection (1), the lower limit shall be~~ AND WHERE THE STATE DEPARTMENT HAS INSTITUTED A PROGRAM OF COMPETITIVE BIDDING PROVIDED IN SUBSECTION (3) OF SECTION 26-4-113, THE STATE DEPARTMENT MAY UTILIZE 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 AND 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) (c)~~. For the purposes of this ~~paragraph (b)~~ SUBSECTION (1), a "qualified actuary" shall be a person deemed as such under regulations promulgated by the commissioner of insurance.

~~(e) (d)~~ A federally qualified health center, as defined in the federal "Social Security Act", shall be reimbursed by the state department for the total reasonable costs incurred by the center in providing health care services to all recipients of medical assistance.

~~(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.~~

(7) WITHIN THIRTY DAYS FROM THE BEGINNING OF EACH FISCAL YEAR, THE STATE DEPARTMENT, IN COOPERATION WITH THE MCOs, SHALL SET A TIMELINE FOR THE RATE-SETTING PROCESS FOR THE FOLLOWING FISCAL YEAR'S RATES AND FOR THE PROVISION OF BASE DATA TO THE MCOs THAT IS USED IN THE CALCULATION OF THE RATES, WHICH SHALL INCLUDE BUT NOT BE LIMITED TO THE INFORMATION INCLUDED IN SUBSECTION (8) OF THIS SECTION.

(8) THE STATE DEPARTMENT SHALL IDENTIFY AND MAKE AVAILABLE TO THE MCOs THE BASE DATA USED IN THE CALCULATION OF THE DIRECT HEALTH CARE COST OF PROVIDING THESE SAME SERVICES ON AN ACTUARIALLY EQUIVALENT COLORADO MEDICAID POPULATION GROUP CONSISTING OF UNASSIGNED RECIPIENTS AND RECIPIENTS IN THE PRIMARY CARE PHYSICIAN PROGRAM PROVIDED IN SECTION 26-4-118. THE STATE DEPARTMENT SHALL CONSULT WITH THE MCOs REGARDING ANY AND ALL ADJUSTMENTS IN THE BASE DATA MADE TO ARRIVE AT THE CAPITATION PAYMENTS.

(9) FOR CAPITATION PAYMENTS EFFECTIVE ON AND AFTER JULY 1, 2003, THE STATE DEPARTMENT SHALL RECALCULATE THE BASE CALCULATION EVERY THREE YEARS. THE THREE YEAR CYCLE FOR THE RECALCULATION OF THE BASE CALCULATION SHALL BEGIN WITH CAPITATION PAYMENTS EFFECTIVE FOR FISCAL YEAR 2003-04. IN THE YEARS IN WHICH THE BASE CALCULATION IS NOT RECALCULATED, THE STATE DEPARTMENT SHALL ANNUALLY TREND THE BASE CALCULATION AFTER CONSULTING WITH THE MCOs. THE STATE DEPARTMENT SHALL TAKE INTO CONSIDERATION WHEN TRENDING THE BASE CALCULATION ANY PUBLIC POLICY CHANGES THAT AFFECT REIMBURSEMENT UNDER THE "COLORADO MEDICAL ASSISTANCE ACT".

(10) THE RATE-SETTING PROCESS REFERENCED IN SUBSECTION (7) OF THIS SECTION SHALL INCLUDE A TIME PERIOD AFTER THE MCOs HAVE RECEIVED THE DIRECT HEALTH CARE COST OF PROVIDING THESE SAME SERVICES ON AN ACTUARIALLY EQUIVALENT COLORADO MEDICAID POPULATION GROUP CONSISTING OF UNASSIGNED RECIPIENTS AND RECIPIENTS IN THE PRIMARY CARE PHYSICIAN PROGRAM PROVIDED IN SECTION 26-4-118, FOR EACH MCO TO SUBMIT TO THE STATE DEPARTMENT THE MCO'S CAPITATION PAYMENT PROPOSAL, WHICH SHALL NOT EXCEED NINETY-FIVE PERCENT OF THE DIRECT HEALTH CARE COST OF PROVIDING THESE SAME SERVICES ON AN ACTUARIALLY EQUIVALENT COLORADO MEDICAID POPULATION GROUP CONSISTING OF UNASSIGNED RECIPIENTS AND RECIPIENTS IN THE PRIMARY CARE PHYSICIAN PROGRAM PROVIDED IN SECTION 26-4-118. THE STATE DEPARTMENT SHALL PROVIDE TO THE MCOs THE MCO'S SPECIFIC ADJUSTMENTS TO BE INCLUDED IN THE CALCULATION OF THE MCO'S PROPOSAL. EACH MCO'S CAPITATION PAYMENT PROPOSAL SHALL MEET THE REQUIREMENTS OF SECTION 26-4-115 (k) AND (k.1).

(11) FOR CAPITATION PAYMENTS EFFECTIVE ON AND AFTER JULY 1, 2003, UNLESS OTHERWISE REQUIRED BY FEDERAL LAW, THE STATE DEPARTMENT SHALL CERTIFY, THROUGH A QUALIFIED ACTUARY RETAINED BY THE STATE DEPARTMENT, THAT THE CAPITATION PAYMENTS SET FORTH IN THE CONTRACT BETWEEN THE STATE

DEPARTMENT AND THE MCOS COMPLY WITH ALL APPLICABLE FEDERAL AND STATE REQUIREMENTS THAT GOVERN SAID CAPITATION PAYMENTS.

(12) EFFECTIVE ON AND AFTER JULY 1, 2003, THE CAPITATION PAYMENTS CERTIFIED BY THE QUALIFIED ACTUARY UNDER SUBSECTION (11) OF THIS SECTION SHALL NOT BE SUBJECT TO ANY DISPUTE RESOLUTION PROCESS, INCLUDING ANY SUCH PROCESS SET FORTH IN ANY SETTLEMENT AGREEMENT ENTERED INTO PRIOR TO THE EFFECTIVE DATE OF THIS SUBSECTION (12).

**SECTION 8.** 26-4-120 (2), Colorado Revised Statutes, is amended to read:

**26-4-120. State department - privatization.** (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):

**SECTION 9. Appropriation - adjustments to the 2002 long bill.** (1) For the implementation of this act, appropriations made in the annual general appropriation act for the fiscal year beginning July 1, 2002, shall be adjusted as follows:

(a) The general fund appropriation to the department of health care policy and financing, medical programs administration, is decreased by thirty thousand eight hundred ninety-nine dollars (\$30,899). In addition, the general assembly anticipates that, for the fiscal year beginning July 1, 2002, the department of health care policy and financing is not anticipated to receive thirty thousand eight hundred ninety-eight dollars (\$30,898) in federal funds for the implementation of this act. Although the federal funds are not appropriated in this act, they are noted for the purpose of indicating the assumptions used relative to these funds.

(b) The general fund appropriation to the department of health care policy and financing, medical services premiums, is decreased by two hundred twenty-seven thousand nine hundred seventy-nine dollars (\$227,979). In addition, the general assembly anticipates that, for the fiscal year beginning July 1, 2002, the department of health care policy and financing is not anticipated to receive two hundred twenty-seven thousand nine hundred seventy-nine dollars (\$227,979) in federal funds for the implementation of this act. Although the federal funds are not appropriated in this act, they are noted for the purpose of indicating the assumptions used relative to these funds.

(c) The general fund appropriation to the department of health care policy and financing, indigent care program, is decreased by one hundred fourteen thousand fifty-one dollars (\$114,051).

**SECTION 10. Effective date - applicability.** This act shall take effect July 1, 2002, and shall apply to contracts issued, renewed, or amended on or after said date.

**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: May 30, 2002