

University of Denver

Digital Commons @ DU

All Publications (Colorado Legislative Council)

Colorado Legislative Council Research
Publications

12-1996

0424 State Medicaid System

Colorado Legislative Council

Follow this and additional works at: https://digitalcommons.du.edu/colc_all

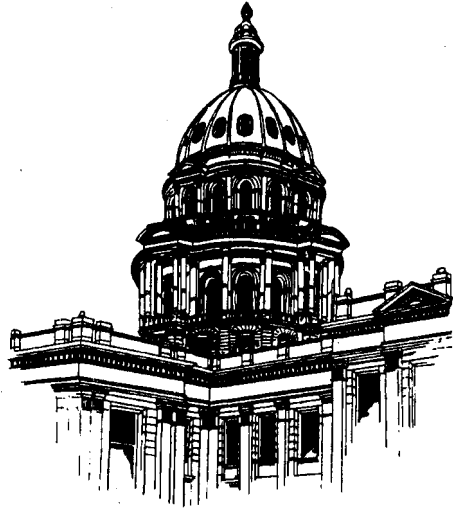
Recommended Citation

Colorado Legislative Council, "0424 State Medicaid System" (1996). *All Publications (Colorado Legislative Council)*. 432.

https://digitalcommons.du.edu/colc_all/432

This Article is brought to you for free and open access by the Colorado Legislative Council Research Publications at Digital Commons @ DU. It has been accepted for inclusion in All Publications (Colorado Legislative Council) by an authorized administrator of Digital Commons @ DU. For more information, please contact jennifer.cox@du.edu, dig-commons@du.edu.

0424 State Medicaid System



Statewide

Medicaid

System

Committee

Report to the

COLORADO

LEGISLATIVE COUNCIL

Colorado Legislative Council
Research Publication No. 424
December 1996

RECOMMENDATIONS FOR 1997

STATEWIDE MEDICAID SYSTEM

**Report to the
Colorado General Assembly**

**Research Publication No. 424
December 1996**

COLORADO GENERAL ASSEMBLY

EXECUTIVE COMMITTEE

Sen. Tom Norton, Chairman
Rep. Chuck Berry, Vice Chairman
Sen. Michael Feeley
Sen. Jeffrey Wells
Rep. Tim Foster
Rep. Peggy Kerns

STAFF

Charles S. Brown, Director
David Hite, Deputy Director
Stanley D. Eloffson, Asst. Director



LEGISLATIVE COUNCIL

ROOM 029 STATE CAPITOL
DENVER, COLORADO 80203-1784
(303) 866-3521 FAX: 866-3855 TDD: 866-3472

COMMITTEE

Sen. Tom Norton, Chairman
Rep. Chuck Berry, Vice Chairman
Sen. Tilman Bishop
Sen. Rob Hernandez
Sen. Bob Martinez
Sen. Ray Powers
Sen. Bill Schroeder
Sen. Bill Thiebaut
Rep. Vickie Agler
Rep. Diana DeGette
Rep. Jeanne Faatz
Rep. Phil Pankey
Rep. Peggy Reeves
Rep. Paul Schauer

December 30, 1996

To Members of the Sixty-first General Assembly:

Submitted herewith is the final report of the Statewide Medicaid System Committee. This committee is created pursuant to Senate Joint Resolution 96-29 — An Interim Study Concerning the Statewide Medicaid System.

At its meeting on October 10, 1996, the Legislative Council reviewed a preliminary report of this committee. A motion to forward this report and the bills therein for consideration in the 1997 session was approved.

Respectfully submitted,

/s/ Senator Tom Norton
Chairman
Legislative Council

TN/JH/eg

TABLE OF CONTENTS

	PAGE
LETTER OF TRANSMITTAL	iii
TABLE OF CONTENTS	v
RECOMMENDED BILLS	vii
MEMBERS OF THE COMMITTEE	ix
EXECUTIVE SUMMARY	xi
Committee Charge	xi
Committee Activities	xi
Committee Recommendations	xi
STATUTORY AUTHORITY AND RESPONSIBILITIES	1
COMMITTEE ACTIVITIES	3
Medicaid and Federal Welfare Reform	4
Current Status of Managed Care in the Medicaid Program	4
Mental Health Medicaid Capitation Program	4
Medicaid Fraud	5
Arizona's Health Care Cost Containment System (AHCCCS)	5
Senate Bill 96-47 — Concerning Adjustments to State Medical Assistance Programs	6
Uninsured and Underinsured	7
SUMMARY OF RECOMMENDATIONS	9
Bill A — Medicaid Managed Care	9
Bill B — Personal Identification Systems for Recipients of Publicly Funded Assistance	11

RECOMMENDED BILLS

	PAGE
Bill A — Concerning Medicaid Managed Care	13
Bill B — Concerning Personal Identification Systems for Recipients of Publicly Funded Assistance	35

STATEWIDE MEDICAID SYSTEM

Members of the Committee

Senator Sally Hopper, Chairman	Ms. Kathy Arnold
Representative Mary Ellen Epps, Vice Chairman	Ms. Sheryl Bellinger
Senator Mike Coffman	Mr. Douglas Clinkscales
Senator James Rizzuto	Ms. Bonnie Good
Representative Nolbert Chavez	Mr. Art Hogling
Representative Tony Grampas	Ms. Barbara McDonnell
Representative David Owen	Ms. Marguerite Salazar
Representative Phil Pankey	Mr. Alan Weil
	Vacancy

Legislative Council Staff

Janis Baron Senior Analyst II	Lorraine Dixon-Jones Research Associate
----------------------------------	--

Office of Legislative Legal Services

Margaret Coate Staff Attorney	Jeremiah Barry Staff Attorney
----------------------------------	----------------------------------

EXECUTIVE SUMMARY

Committee Charge

The Statewide Medicaid System Interim Committee was established by Senate Joint Resolution 96-29. This committee was formed to address the costs of the state's medical assistance program and explore methods for controlling costs without adversely affecting access and quality medical care. The committee was directed to analyze the interrelationship among the needs of the underinsured, uninsured, and Medicaid recipients in Colorado, consider implementation of cost containment measures, and make recommendations on legislation.

Committee Activities

The committee heard testimony and discussed recommendations for legislative action during six days of meetings from August through December of 1996. Testimony was given by health care providers, consumer advocate groups, local government providers, members of the Medical Assistance Reform Advisory Committee, and Medicaid recipients. Testimony also was provided by representatives of the Department of Health Care Policy and Financing, the Department of Law, and the Denver Health Medical Center.

Committee Recommendations

As a result of these hearings, the committee recommends two bills to the Colorado General Assembly.

Bill A — Concerning Medicaid Managed Care. Bill A requires the Department of Health Care Policy and Financing (DHCPF) to implement managed care for 75 percent of the Medicaid population statewide. DHCPF must annually submit recommendations for any exemptions from this requirement. The bill also provides for up to 20 percent privatization of Medicaid administration, if deemed cost-effective by the Joint Budget Committee.

Bill B — Concerning Personal Identification Systems for Recipients of Publicly Funded Assistance. Bill B mandates the use of social security numbers for identifying applicants for public or medical assistance. In addition, the bill creates a committee to propose security methods for verifying the eligibility of this population to prevent fraud.

STATUTORY AUTHORITY AND RESPONSIBILITIES

The Interim Study Concerning the Statewide Medicaid System was established by Senate Joint Resolution 96-29. The resolution stated that Colorado's medical assistance program has increased at a rate faster than any other single state budget item and that the state must explore methods for controlling costs without adversely affecting quality of and access to medical care. The resolution established an interim Legislative Council committee with members representing the business community, state government, providers in the Medicaid program, Medicaid recipients, and members of the General Assembly.

The committee was directed to study and report its recommendations on policies or legislation relating to the medical assistance program and to consider the following:

- the interrelationship among the needs of the underinsured, uninsured, and Medicaid recipients, particularly as needs reflect impediments to medical assistance recipients being able to discontinue reliance on such assistance;
- implementation of cost containment measures, such as managed care; and
- enhanced systems to manage care, collect data, and measure quality, access, and health outcomes.

COMMITTEE ACTIVITIES

The Statewide Medicaid System Committee heard testimony and discussed recommendations for legislative action during six days of meetings from August through December 1996. As a result of this testimony, the committee recommends two bills and determined the following:

- Senate Bill 96-47 — *Concerning Adjustments To State Medical Assistance Programs* would be the basis for new legislation. Senate Bill 96-47 was postponed indefinitely in the Senate Health, Environment, Welfare and Institutions (HEWI) Committee in April 1996. Senate Bill 96-47 was the recommended legislation of the State Medical Assistance Reform Advisory Committee, established pursuant to Senate Bill 93-122 (Section 26-4-704, C.R.S.) The State Medical Assistance Reform Advisory Committee met over a two-year period (1993 through 1995) with the charge to offer an alternative plan designed to reduce the state's cost in participating in the federal Medicaid program;
- managed care must provide consumers with the right to choose among competing plans and a system to inform them of choices;
- managed care must include a grievance process;
- the state should study the viability of implementing a consumer certificate of choice program; and
- community health centers may be negatively impacted by Medicaid managed care, thus affecting the uninsured and underinsured who receive medical care at these centers.

During six days of hearings, the task force heard testimony in the following areas:

- Medicaid and federal welfare reform;
- Current status of managed care administered by the Department of Health Care Policy and Financing;
- the Mental Health Medicaid Capitation Program administered by the Department of Human Services;
- Medicaid fraud;
- Arizona's Health Care Cost Containment System (AHCCCS);
- Senate Bill 96-47; and
- Uninsured and underinsured individuals.

Medicaid and Federal Welfare Reform

A representative of the Department of Health Care Policy and Financing (DHCPF) and staff to the Joint Budget Committee provided testimony on the impact to the Medicaid program as a result of P.L. 104-193 — *The Personal Responsibility And Work Opportunity Reconciliation Act Of 1996*, signed by President Clinton in August 1996, and commonly referred to as federal welfare reform. This legislation marks three changes to Medicaid:

- severs the automatic link between Aid to Families with Dependent Children (AFDC) eligibility and Medicaid;
- bars current and future legal immigrants from receiving supplemental security income (SSI) until they become citizens; and
- eliminates references to maladaptive behavior from the SSI disability standard for children.

Current Status of Managed Care in the Medicaid Program

The committee was given an overview of the Medicaid program in addition to an update on the current status of managed care by representatives of the DHCPF. Statistics were provided on the number of persons in managed care, eligibility requirements, services by eligibility, per capita costs, and Medicaid expenditures by type of service. It was noted, that although 20 percent of Medicaid enrollees are in managed care, less than 20 percent of the Medicaid funding is going to managed care. For Fiscal Year 1996-97, the department estimates that 279,053 persons will be enrolled in Medicaid. Of this number, 71,396 persons are estimated to be in health maintenance organization (HMO) plans; 159,579 persons are estimated to be in the mental health capitation program; and 65,043 are estimated to be in the primary care physician program. Speed of expansion, eligibility categories, quality assurance, rates, and mandatory versus voluntary enrollment are the outstanding issues in implementing managed care for Medicaid enrollees.

Mental Health Medicaid Capitation Program

Testimony from representatives of the Department of Human Services (DHS) was provided on the Mental Health Medicaid Capitation Program. House Bill 92-1306 — *Concerning The Delivery Of Services Pursuant To The "Colorado Medical Assistance Act" Through Managed Care, And Making An Appropriation Therefor*, authorized the DHS and DHCPF to study the feasibility of developing a prepaid managed care system for providing comprehensive mental health services to Medicaid beneficiaries in the state. A pilot program was implemented by September 1995.

Testimony was provided that a final report on program evaluations is due to the General Assembly on January 1, 1997. Thorough client satisfaction survey and formal evaluations were being conducted on the program, and preliminary data indicates a reduction in costs and an increase in community services. Regarding client satisfaction and responsiveness, it was stated that the toll free 1-800 hotline and grievance procedures allow for complaints to be handled quickly at the local level.

The executive director of the Weld County Mental Health Center provided testimony on the Weld County program. In addition to achieving significant cost savings, the program has expanded client services, added walk-in treatment, and developed a children's program under capitation. It was stated that overall, the Weld County program provides consumers with greater access to the services they actually need.

Medicaid Fraud

Representatives of the DHCPF and the Department of Law testified on Medicaid fraud. A DHCPF representative stated that the department refers fraud cases to the Department of Law and the Department of Regulatory Agencies, State Board of Medical Examiners. The DHCPF checks for aberrant billings and conducts consumer surveys regarding Medicaid services received and billed.

The director of the Colorado Medicaid Fraud Unit in the Department of Law provided an overview of unit investigations and prosecutions. In order to prosecute criminally, there must be admissible evidence showing a clear pattern of fraud, substantial illicit overpayment, and a determination that over billing is not accidental. The director testified that fraud would not disappear under managed care, but instead would take a different form. The HMOs in other states are being prosecuted for violations, some of which include the following:

- submitting false cost data to obtain higher capitation rates;
- marketing fraud to gain enrollment;
- listing fictitious enrollees;
- padding data to get higher capitation rates; and
- failing to provide medically necessary services.

Arizona's Health Care Cost Containment System (AHCCCS)

The committee heard testimony from a representative of the Denver Health and Human Services Department on AHCCCS, who previously served as the health plan medical director in Arizona. She explained that Arizona was the first state to provide managed care starting in 1982. Prior to implementing managed care, the state did not participate in Medicaid, and medical services for indigent persons were funded through the counties. Features and problems of AHCCCS that were discussed included provider

insolvency, program administration, contract bidding, a “carve out” (exemption from enrollment in managed care) of mental health and long-term care recipients, and implementation in rural areas. Lessons learned from AHCCCS include the following:

- avoid inexperienced management contractors;
- assess abilities to assume risk carefully;
- implement a state-of-the-art management information system;
- consider annual open enrollment;
- ensure that all plans operate on a level playing field (i.e., all plans should be assuming all categories of risk such as disabled and chronically ill clients);
- consider risk pooling arrangements at the state level for special needs groups;
- avoid political deals;
- require and monitor effective communication between plans and carved out services; and
- implement strong provisions to monitor fraud and abuse.

Senate Bill 96-47 — Concerning Adjustments to State Medical Assistance Programs

Senate Bill 96-47 was the recommended legislation of the State Medical Assistance Reform Advisory Committee. The committee was established pursuant to Senate Bill 93-122 (Section 26-4-704, C.R.S.). The committee met over a two-year period (1993 through 1995) with the charge to offer an alternative plan designed to reduce the state’s cost in participating in the federal Medicaid program. Senate Bill 96-47 attempted to address the issue of solvency of the provider, required data collection, included a consumer choice pilot program, and required expansion of the number of recipients into managed care. The bill was postponed indefinitely in the Senate HEWI Committee in April 1996. Senate Joint Resolution 96-29 was enacted to continue the effort of the State Medical Assistance Reform Advisory Committee and respond to the postponement of Senate Bill 96-47.

The Statewide Medicaid System Committee determined in its first meeting that a bill to implement managed care would be recommended, and that Senate Bill 96-47 would be the framework and basis for new legislation. The committee devoted three meeting days to discussion of Senate Bill 96-47 and heard testimony from members of the State Medical Assistance Reform Advisory Committee, Medicaid providers, advocacy groups, and Medicaid clients on the bill. Considerable time was spent on how best to implement managed care with the support of Medicaid providers, Medicaid recipients, advocates, and state government.

Groups that testified before the Statewide Medicaid System Committee regarding Senate Bill 96-47 include: Colorado Patients’ Rights and Responsibilities, Protection and Advocacy for Individuals with Mental Illness, Catholic Charities, Legal Aid, the Home Care Association, the Colorado Health Care Association, the Colorado

Association of Family and Children's Agencies, the State Long-Term Care Ombudsman, and the Colorado Cross-Disability Coalition. Similar concerns were expressed by these organizations, including the following:

- need for adequate protection for clients in both statute and regulation;
- need for adequate grievance and appeals process;
- need for independent external review;
- need for enforcement to assure consumer protection;
- need for consumer choice;
- advisability of limiting access to medical specialists; and
- mandating populations into managed care will jeopardize quality.

Two members of the State Medical Assistance Reform Advisory Committee testified on Senate Bill 96-47. A majority of members of the committee believed that individuals requiring long-term care, chronically ill individuals, or persons with disabilities can be in managed care, but the risk factors for these groups need to be changed to determine capitation costs. It was emphasized that without consumer input, the system would be driven by providers instead of consumers.

At its September 24th meeting, the Statewide Medicaid System Committee did not hear any formal testimony. This meeting was devoted to committee discussion on relevant issues in a Medicaid managed care system to be included in new legislation. These issues included the following:

- who should be covered;
- client choice;
- pricing and risk sharing;
- effects on the health care market;
- administrative changes requiring waivers;
- facilitators;
- disclosure requirements;
- grievance procedures;
- limitations on expenditures; and
- consumer input.

Uninsured and Underinsured

Representatives from the Department of Health Care Policy and Financing noted that, based on 1993 data, the sources of insurance for Colorado citizens were as follows:

private coverage	68 percent
Medicare	10 percent
Medicaid	6 percent
uninsured	16 percent

The uninsured access care through the following programs: the Colorado Medically Indigent Program, the Child Health Plan, Colorado Uninsurable Health Insurance, and the Kaiser Connections Program. It was noted that this population receive a disproportionate share of services from community health centers and emergency rooms.

Representatives of Colorado community health centers (CHCs) testified that the centers provide a significant proportion of health care to the uninsured and underinsured, as well as for Medicaid clients. In 1995, patients with no insurance accounted for 64 percent of health center patients, while Medicaid recipients accounted for 35 percent of patients. Consequently, Medicaid is an important revenue source for CHCs. If CHCs do not receive contracts under Medicaid managed care, their existence may be jeopardized.

SUMMARY OF RECOMMENDATIONS

As a result of the committee's activities, the following bills are recommended to the Colorado General Assembly.

Bill A — Medicaid Managed Care

Bill A provides for the following:

- ***Statewide managed care system.*** Subject to the receipt of federal waivers, requires the state Department of Health Care Policy and Financing to enroll 75 percent of Colorado's Medicaid recipients in a managed care system by July 1, 2000. Additionally, requires the following to be implemented statewide by July 1, 2000:
 - 1) Acute and long-term care pilot program;
 - 2) Limited enrollment managed care contracts;
 - 3) Managed mental health services; and
 - 4) Program of all-inclusive care for the elderly.
- ***Managed care organizations.*** Requires the Medical Services Board to develop criteria for selecting Medicaid managed care organizations (MCOs). In addition, outlines specific criteria that all MCOs must meet including that the MCO: (1) will not interfere with appropriate medical care decisions by the provider; (2) will not provide inducements in exchange for the recipient selecting its plan; and (3) will establish a grievance procedure which allows for timely resolution.
- ***Quality measurements.*** Specifies the criteria that DHCPF must use to measure quality and authorizes the department to promulgate rules to clarify and administer the measurements.
- ***Required features of managed care system.*** Establishes the general features that Medicaid managed care programs must contain, including the recipients' right to choose among competing plans, procedures to inform recipients of choices available, and the process for monitoring reasons for disenrollment. Repeals current provisions requiring managed care providers to allow recipients to disenroll at any time. Requires the MCO to implement grievance procedures, including a process for expedited review. Authorizes the Medical Services Board to promulgate rules concerning the marketing of coverage programs.
- ***DHCPF recommendations*** regarding exemptions from managed care. By December 1 of each year, requires the DHCPF to make written recommendations to the General Assembly concerning necessary

exemptions from the requirement that managed care be implemented for 75 percent of the Medicaid population. States that the General Assembly recognizes that capitated care may not be appropriate for some segments of the Medicaid population. For example, rural Medicaid recipients may not have a choice of plans and special needs clients may not be able to access needed services from MCOs.

- ***Primary care physician program.*** Authorizes a primary care physician (PCP) program under which the PCP is solely authorized to provide primary care and referral to all necessary specialty services.
- ***Special needs populations.*** Requires DHCPF to establish capitation rates that include risk adjustments, reinsurance, or stop-loss funding methods for special needs populations. States that all such methods shall not allow a plan to receive more than it would have under fee-for-service.
- ***Privatization.*** Requires DHCPF to hire independent contractors to administer up to 20 percent of the statewide managed care program, if the Joint Budget Committee finds that such privatization would be cost-effective.
- ***Data collection.*** Identifies the types of data that providers must supply to DHCPF. It requires the department to compile data on health outcomes and to evaluate the cost-efficiency of the state's managed care programs, except for the PCP program. This health data analysis is to be submitted to the House and Senate Health, Environment, Welfare, and Institutions Committees by July 1, 1999, and each fiscal year thereafter.
- ***Consumer certificate choice program.*** Requires the DHCPF to submit to the General Assembly, by January 1, 1998, a list of options and recommendations for the implementation of a consumer certificate choice program. Lists issues to be covered and requires recommendations concerning the inclusion of the medically indigent population in this program.

Bill B — Personal Identification Systems for Recipients of Publicly Funded Assistance

Bill B is designed to prevent and detect public and medical assistance fraud. The bill provides for the following:

- Mandates the Departments of Human Services and Health Care Policy and Financing to use social security numbers as a method of identifying every person applying for public assistance and medical assistance. Authorizes the departments to seek any necessary federal waivers.
- Creates the Personal Identification Committee to evaluate and propose security methods to be used in verifying eligibility for public assistance and medical assistance. Requires the security measures to be studied to include: personal identification numbers, photo identification, fingerprint identification, or retinal scanning. Directs the committee to be composed of ten members, five appointed jointly by the Speaker of the House of Representatives and the President of the Senate and five to be appointed by the Governor.
- Charges the Departments of Human Services and Health Care Policy and Financing to report to the General Assembly on their plans for implementing committee recommendations within 90 days of receiving such recommendations.

Bill A

A BILL FOR AN ACT

CONCERNING MEDICAID MANAGED CARE.

Bill Summary

"Medicaid Managed Care"

(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments which may be subsequently adopted.)

- **Legislative declaration.** Describes the historical impact of federal medicaid requirements on the state and the opportunity that Colorado has to tailor the state medical assistance program to the state's particular needs.
- **Statewide managed care system.** Subject to the receipt of federal waivers, requires the state department of health care policy and financing to implement a plan pursuant to which, by July 1, 2000, 75% of Colorado's medical assistance recipients are in a managed care plan. Requires the following to be implemented statewide by July 1, 2000:
 - 1) Acute and long-term care pilot program;
 - 2) Limited enrollment managed care contracts;
 - 3) Managed mental health services; and
 - 4) Program of all-inclusive care for the elderly.
- **Managed care organizations.** Requires the medical services board to establish criteria under which medicaid managed care organizations (MCO's) would be selected. States specific criteria that all MCO's must meet for which the state department must verify compliance.
- **Quality measurements.** States the criteria that the state department must use to measure quality and authorizes the state department to promulgate rules to clarify and administer the measurements
- **Required features of managed care system.** Establishes the general features that all medicaid managed care programs must contain, including the recipients' right to choose among competing plans, plans

to inform recipients of choices available, plans for the monitoring of reasons for disenrollment, complaint and grievance procedures, provisions for billing recipients, and required compliance with insurance division regulations concerning marketing of the programs.

- **Primary care physician program - special needs.** Authorizes a primary care physician program. Requires the state department to establish capitation rates that include risk adjustments, reinsurance, or stop-loss funding methods for special needs populations. States that all such methods shall not allow a plan to receive more than it would under a fee-for-service plan. Authorizes the state department to develop a program for financial incentives for superior quality of service.
 - **Privatization.** Subject to a finding of cost-effectiveness by the joint budget committee of the general assembly, requires the state department to hire independent contractors to administer up to 20% of the statewide managed care program.
 - **Data collection.** Identifies the types of data that providers must supply to the state department. Requires the state department to compile data on health outcomes and to evaluate the cost-efficiency of the state's managed care programs.
 - **Consumer certificate choice program.** Requires the state department to submit to the general assembly a list of options and recommendations for the implementation of a consumer certificate choice program. Lists issues to be covered and requires recommendations concerning the inclusion of the medically indigent population in the consumer choice certificate program.
 - **Disenrollment from managed care.** Repeals provision requiring managed care providers to allow recipients to disenroll at any time.
 - **Technical changes.** Makes conforming amendments, relocates certain provisions, and repeals the relocated provisions.
-

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.
(+) 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 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) 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, 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) ALL MANAGED CARE CONTRACTS AND PILOT PROJECTS IN EFFECT AS OF JULY 1, 1997, SHALL 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 CONTRACTS OR 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 FUNDED BY THE ROBERT WOOD JOHNSON FOUNDATION TO STUDY THE INTEGRATION OF ACUTE AND LONG-TERM CARE, AS DESCRIBED IN SECTION 26-4-121;

(II) **Managed care contracts.** LIMITED ENROLLMENT IN MANAGED CARE FOR MEDICAL ASSISTANCE RECIPIENTS IN MESA COUNTY, PUEBLO COUNTY, AND THE DENVER METROPOLITAN AREA;

(III) **Mental health.** MANAGED MENTAL HEALTH SERVICES, AS DESCRIBED IN SECTION 26-4-122 [FORMERLY 26-4-528];

(IV) **Elderly.** PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY, AS DESCRIBED IN SECTION 26-4-123 [FORMERLY 26-4-519];

(3) 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 UNDER THE FEDERAL AID TO FAMILIES WITH DEPENDENT CHILDREN PROGRAM, DESCRIBED IN PART 2 OF ARTICLE 2 OF THIS TITLE, OR ANY SUCCESSOR PROGRAM.

(4) 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) 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 26-4-121 AND THE PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY DESCRIBED IN SECTION 26-4-123. THE STATE DEPARTMENT'S ASSESSMENT SHALL INCLUDE CONSIDERATION OF COMMENTS AND INPUT FROM LONG-TERM CARE PROVIDERS, RECIPIENTS, 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.

26-4-114. Managed care organizations - definitions. (1) (a) **Managed care.** AS USED IN THIS SUBPART 2, "MANAGED CARE" MEANS THE DELIVERY BY A MANAGED CARE ORGANIZATION, AS DEFINED IN SUBSECTION (2) OF THIS SECTION, OF A PREDEFINED SET OF SERVICES TO RECIPIENTS.

(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" OR "MCO" MEANS AN ORGANIZATION SELECTED BY A HEALTH CARE COVERAGE COOPERATIVE OR BY THE STATE DEPARTMENT IN ACCORDANCE WITH RULES ESTABLISHED BY THE MEDICAL SERVICES BOARD TO DIRECTLY PROVIDE OR TO CONTRACT WITH PROVIDERS THAT WILL RENDER HEALTH CARE SERVICES TO RECIPIENTS PURSUANT TO THIS SUBPART 2.

26-4-115. Selection of managed care organizations. (1) THE MEDICAL SERVICES BOARD AFTER PUBLIC HEARING AND INPUT FROM RECIPIENTS 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;
- (b) THE MCO WILL MAKE OR ASSURE PAYMENTS TO PROVIDERS WITHIN THE TIME ALLOWED UNDER SECTION 10-4-708, 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;

(f) APPROPRIATE USE OF ANCILLARY HEALTH CARE PROVIDERS SUCH AS PHYSICAL THERAPISTS, OCCUPATIONAL THERAPISTS, SPEECH PATHOLOGISTS, AND ADVANCED PRACTICE NURSES;

(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 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, DETERMINE THE DEGREE OF MEDICAL ACCESS, AND REVEAL RECIPIENT SATISFACTION AND HABITS. SUCH TOOLS SHALL INCLUDE THE USE OF CLIENT SURVEYS AND ANECDOTAL 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 EXAMINE THE PREGNANT WOMAN WITHIN TWO WEEKS AFTER HER ENROLLMENT;

(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 EPSDT FOR CHILDREN AND PAP SMEARS 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.

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.

(b) QUALITY SHALL FOCUS ON HEALTH STATUS AND ILLNESS, 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 IS DOING BUSINESS IN AN AREA ACCESSIBLE TO 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. THIS FUNCTION SHALL ENSURE THAT CONSUMERS HAVE INFORMED CHOICE AMONG AVAILABLE OPTIONS TO ASSURE THE FULLEST POSSIBLE VOLUNTARY PARTICIPATION IN MANAGED CARE. THE FACILITATOR MAY 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.

(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. 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 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.

(c) **Billing medicaid recipients.** NOTWITHSTANDING 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.

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.

(3) (a) THE STATE DEPARTMENT SHALL DEVELOP CAPITATION RATES 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.

(b) 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 REQUIRING CONTINUOUS SPECIALIZED CARE AND TREATMENT OF CHRONIC, CONGENITAL, AND ACQUIRED 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.

(c) THE RISK ADJUSTMENT, REINSURANCE, OR STOP-LOSS FUNDING METHODS DEVELOPED BY THE STATE DEPARTMENT PURSUANT TO PARAGRAPH (a) OF THIS SUBSECTION (3) 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.

(d) UNDER NO CIRCUMSTANCES SHALL THE RISK ADJUSTMENTS, REINSURANCE, OR STOP-LOSS METHODS DEVELOPED BY THE STATE DEPARTMENT PURSUANT TO PARAGRAPH (a) OF THIS SUBSECTION (3) 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.

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

26-4-119. 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 UP TO 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 FINDING BY THE JOINT BUDGET COMMITTEE OF THE GENERAL ASSEMBLY THAT PRIVATIZATION OF THE MANAGED CARE SYSTEM IS COST-EFFICIENT, AND THIS

SECTION SHALL BE IMPLEMENTED ONLY TO THE EXTENT THAT PRIVATIZATION IS COST-EFFICIENT. IN ADDITION, THE IMPLEMENTATION OF THIS SECTION SHALL BE CONTINGENT UPON 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.

26-4-120. 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; EXCEPT THAT, FOR THE PURPOSES OF THIS SECTION, A MANAGED CARE PROGRAM DOES NOT INCLUDE THE PRIMARY CARE PHYSICIAN PROGRAM. 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 FOR INDIVIDUALS, 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.

(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 AND IMPLEMENT 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.

(3) IN ADDITION TO ANY OTHER DATA COLLECTION AND REPORTING REQUIREMENTS, EACH PROVIDER OR MANAGED CARE ORGANIZATION THAT PARTICIPATES IN THE STATE MEDICAL ASSISTANCE PROGRAM TO PROVIDE

SERVICES UNDER A MANAGED CARE PLAN, PROGRAM, OR COMPONENT OF THE STATE MEDICAL ASSISTANCE PROGRAM SHALL SUBMIT THE FOLLOWING TYPES OF DATA TO THE SYSTEM FOR ACCESS BY THE STATE DEPARTMENT:

- (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; AND
- (e) HEALTH STATUS OF CONSUMERS.

26-4-121. Integrated care and financing project. (1) THE STATE DEPARTMENT IS AUTHORIZED TO OVERSEE AND ADMINISTER THE INTEGRATED CARE AND FINANCING PROJECT FUNDED BY THE ROBERT WOOD JOHNSON FOUNDATION TO STUDY THE INTEGRATION OF ACUTE AND LONG-TERM CARE WITHIN THE FOLLOWING GUIDELINES:

- (a) THE PROJECT SHALL BE CONDUCTED IN A COUNTY SELECTED BY THE STATE DEPARTMENT THAT HAS LONG-TERM 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) THE PROJECT SHALL BE FOR PERSONS ELIGIBLE FOR MEDICAL ASSISTANCE AS A CATEGORICALLY NEEDY PERSON.

(e) PARTICIPANTS SHALL BE MEDICAL ASSISTANCE RECIPIENTS ENROLLED IN A HEALTH MAINTENANCE ORGANIZATION; EXCEPT THAT PERSONS WITH DEVELOPMENTAL DISABILITIES AND PERSONS WITH MENTAL ILLNESSES SHALL CONTINUE TO RECEIVE SERVICES UNDER THE APPLICABLE MANAGED CARE SYSTEM FOR THOSE POPULATIONS.

(f) HEALTH SERVICES FOR PARTICIPANTS SHALL BE THE BASIC SERVICES PROVIDED TO THE PRIVATE SECTOR SERVED BY THE HEALTH MAINTENANCE ORGANIZATION IN ADDITION TO THE SERVICES PROVIDED UNDER THE LONG-TERM CARE MANAGED SYSTEM.

(g) THE PROJECT SHALL ADOPT THE FOLLOWING 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; AND SUFFICIENT COLLECTION OF HEALTH DATA AND PARTICIPANT OUTCOMES.

(h) 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.

(i) IN ADDITION TO USING OTHER METHODS OF MEASURING PARTICIPANT SATISFACTION AND OUTCOMES, THE STATE DEPARTMENT SHALL CONDUCT RANDOM SURVEYS TO ASSESS PARTICIPANT SATISFACTION.

26-4-122. 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:

(A) (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

(H) (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.~~

(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.~~

~~(4)~~ (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)~~ ~~(6)~~ (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.

26-4-123. 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.

~~(4-5)~~ (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.)~~

26-4-124. Study of certificate program. (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) ASSESSING QUALITY OUTCOMES FOR A CONSUMER CERTIFICATE CHOICE PROGRAM;
- (e) COLLECTING DATA AND OUTCOME MEASUREMENTS;
- (f) 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.

(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.

26-4-125 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~~ 26-4-123;

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

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 (1) 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).~~

SECTION 8. 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 9. 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.

Bill B

A BILL FOR AN ACT

CONCERNING PERSONAL IDENTIFICATION SYSTEMS FOR RECIPIENTS OF
PUBLICLY FUNDED ASSISTANCE.

Bill Summary

"ID System for Publicly Funded Assistance"

(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments which may be subsequently adopted.)

Statewide Medicaid System Committee. Creates a committee to evaluate and propose appropriate methods of personal identification to be used in verifying eligibility for public assistance and medical assistance. Requires the committee to report its recommendations to the general assembly, the department of human services, and the department of health care policy and financing. Authorizes the departments to seek any necessary federal waivers. Directs that the identification methods selected through this process be used as a condition of eligibility for public assistance and medical assistance. Requires the use of an applicant's social security number as a method of personal identification for every person applying for public assistance or medical assistance.

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

SECTION 1. Legislative declaration. The general assembly hereby finds that welfare fraud has a negative effect on the people of Colorado as well as on the individuals who need and qualify for public assistance and medical assistance. The general assembly also finds that the passage at the

federal level of welfare reform legislation provides an opportunity for states to reassess their eligibility verification processes for persons applying for public assistance and medical assistance. The general assembly, therefore, enacts this bill to study and propose improvements to strengthen the security measures used to prevent and detect welfare fraud and duplicate participation.

SECTION 2. Part 1 of article 2 of title 26, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SECTION to read:

26-2-136. Personal identification systems for public assistance and medical assistance - committee to select methods - repeal. (1) (a) THERE IS HEREBY ESTABLISHED THE PERSONAL IDENTIFICATION COMMITTEE FOR THE PURPOSE OF EVALUATING AND PROPOSING THE SECURITY METHODS TO BE USED BY THE STATE DEPARTMENT FOR VERIFICATION OF ELIGIBILITY WHEN A PERSON APPLIES FOR PUBLIC ASSISTANCE AND BY THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FOR VERIFICATION OF ELIGIBILITY WHEN A PERSON APPLIES FOR MEDICAL ASSISTANCE. THE COMMITTEE SHALL BE COMPRISED OF TEN MEMBERS. FIVE MEMBERS SHALL BE APPOINTED JOINTLY BY THE SPEAKER OF THE HOUSE OF REPRESENTATIVES AND THE PRESIDENT OF THE SENATE AND FIVE MEMBERS SHALL BE APPOINTED BY THE GOVERNOR. OF THE MEMBERS OF THE COMMITTEE JOINTLY APPOINTED BY THE SPEAKER OF THE HOUSE OF REPRESENTATIVES AND THE PRESIDENT OF THE SENATE, ONE SHALL

BE A REPRESENTATIVE OF A COUNTY, ONE SHALL BE A BANKER FAMILIAR WITH AUTOMATED TECHNOLOGY, AND ONE SHALL BE A REPRESENTATIVE OF LAW ENFORCEMENT FAMILIAR WITH METHODS OF SECURITY IDENTIFICATION. OF THE MEMBERS OF THE COMMITTEE APPOINTED BY THE GOVERNOR, ONE SHALL BE A REPRESENTATIVE OF THE BUSINESS COMMUNITY, ONE SHALL BE AN EMPLOYEE OF THE DEPARTMENT OF HUMAN SERVICES, ONE SHALL BE AN EMPLOYEE OF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING, ONE SHALL BE A PROGRAM RECIPIENT, AND ONE SHALL BE A MEMBER OF THE COMMUNITY. APPOINTMENTS SHALL BE MADE WITHIN THIRTY DAYS AFTER THE EFFECTIVE DATE OF THIS SECTION OR NO LATER THAN JULY 1, 1997, WHICHEVER OCCURS FIRST. THE COMMITTEE SHALL SELECT A CHAIRPERSON AND A VICE-CHAIRPERSON FROM AMONG ITS MEMBERS. ALL MEMBERS OF THE COMMITTEE SHALL SERVE WITHOUT COMPENSATION. THE COMMITTEE SHALL SUBMIT A REPORT ON ITS FINDINGS TO THE GENERAL ASSEMBLY, THE STATE DEPARTMENT, AND THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING WITHIN ONE HUNDRED TWENTY DAYS AFTER THE SIGNING OF THIS ACT. SUCH REPORT SHALL CONTAIN ANY LEGISLATIVE OR BUDGET RECOMMENDATIONS NEEDED TO IMPLEMENT THE RECOMMENDATIONS.

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

(2) THE PERSONAL IDENTIFICATION COMMITTEE SHALL STUDY AND PROPOSE WHAT SECURITY MEASURES, SUCH AS INDIVIDUAL PERSONAL

IDENTIFICATION NUMBERS, PHOTO IDENTIFICATION, FINGERPRINT IDENTIFICATION, OR RETINAL SCANNING, SHOULD BE USED TO IDENTIFY APPLICANTS FOR PURPOSES OF DETERMINING WHETHER A PERSON APPLYING FOR PUBLIC ASSISTANCE OR MEDICAL ASSISTANCE IS ELIGIBLE TO RECEIVE SUCH BENEFITS. IN MAKING SUCH RECOMMENDATIONS, THE COMMITTEE SHALL CONSIDER WHICH SECURITY METHODS ARE MOST EFFICIENT AND EFFECTIVE AND WHICH WILL BE THE MOST SUCCESSFUL AT PREVENTING AND DETECTING FRAUD AND DUPLICATE PARTICIPATION. THE STATE DEPARTMENT AND THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING, WITHIN NINETY DAYS AFTER RECEIVING THE COMMITTEE'S REPORT, SHALL REPORT TO THE GENERAL ASSEMBLY ON THEIR PLANS FOR IMPLEMENTING THE COMMITTEE'S RECOMMENDATIONS.

(3) IN ADDITION TO THE SECURITY MEASURES SELECTED PURSUANT TO SUBSECTION (2) OF THIS SECTION, THE STATE DEPARTMENT AND THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING SHALL USE SOCIAL SECURITY NUMBERS AS A METHOD OF PERSONAL IDENTIFICATION FOR EVERY PERSON APPLYING FOR PUBLIC ASSISTANCE OR MEDICAL ASSISTANCE.

(4) THE STATE DEPARTMENT AND THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING ARE AUTHORIZED TO SEEK ANY NECESSARY WAIVERS FROM THE FEDERAL GOVERNMENT TO IMPLEMENT THIS SECTION.

SECTION 3. 26-2-111 (1), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

26-2-111. Eligibility for public assistance. (1) No person shall be granted public assistance in the form of assistance payments under this article unless such person meets all of the following requirements:

(e) THE PERSON SUBMITS TO THE METHOD OR METHODS OF PERSONAL IDENTIFICATION SELECTED PURSUANT TO SECTION 26-2-136 FOR THE RECEIPT OF PUBLIC ASSISTANCE INCLUDING FOOD STAMP BENEFITS; EXCEPT THAT PERSONS WHO ARE PHYSICALLY UNABLE TO SUBMIT TO SUCH METHODS OF PERSONAL IDENTIFICATION, AS DETERMINED PURSUANT TO RULES ADOPTED BY THE STATE BOARD, SHALL BE EXCEPTED FROM THIS REQUIREMENT.

SECTION 4. 26-4-106, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

26-4-106. Application - verification of eligibility. (1.5) NO PERSON SHALL BE ELIGIBLE FOR MEDICAL ASSISTANCE UNDER THIS ARTICLE UNLESS SUCH PERSON SUBMITS TO THE METHOD OR METHODS OF PERSONAL IDENTIFICATION SELECTED PURSUANT TO SECTION 26-2-136 FOR THE RECEIPT OF MEDICAL ASSISTANCE; EXCEPT THAT PERSONS WHO ARE PHYSICALLY UNABLE TO SUBMIT TO SUCH METHODS OF PERSONAL IDENTIFICATION, AS

DETERMINED PURSUANT TO RULES ADOPTED BY THE STATE BOARD, SHALL BE EXCEPTED FROM THIS REQUIREMENT.

SECTION 5. 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.