Medical Assistance Reform Advisory Committee

Report to the

COLORADO

GENERAL ASSEMBLY

Colorado Legislative Council
Research Publication No. 407
October 1995

RECOMMENDATIONS FOR 1996

STATE MEDICAL ASSISTANCE REFORM ADVISORY COMMITTEE

Report to the
Colorado General Assembly

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November 1995

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

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October 30, 1995

To Members of the Sixtieth General Assembly:

Submitted herewith is the final report of the State Medical Assistance Reform Advisory Committee. This committee is a statutory committee established under Section 26-4-704, C.R.S.

At its meeting on October 17, 1995, the Legislative Council reviewed the report of this committee. A motion to forward this report and the bill therein for consideration in the 1996 session was approved.

Respectfully submitted,

/s/ Senator Tom Norton
Chairman
Legislative Council

TN/JH/eg

TABLE OF CONTENTS

RECOMMENDED BILL

State Medical Assistance Reform Advisory Committee

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Executive Summary

Statutory Authority and Responsibility

Colorado law requires the General Assembly to consider legislation prior to July 1, 1996, that would provide an alternative medical assistance program to poor persons in the state. The Office of State Planning and Budgeting was directed to develop such a program, and an alternative plan was submitted to the General Assembly by that office in April 1995. The State Medical Assistance Reform Advisory Committee was charged with reviewing and providing comments on the development of an alternative medical assistance program for the state.

Committee Activities

The Committee met almost monthly from October 1993 through March of 1995. Due to proposed federal budget reductions in the Medicaid Program, the committee began meeting during the summer and fall of 1995. Discussion concentrated primarily on the feasibility of a statewide managed care program and a certificate of choice program for recipients of Medicaid.

Committee Recommendation

Bill A - Adjustments to State Medical Assistance Programs. The bill requires the Department of Health Care Policy and Financing to establish a statewide managed care system over a three year phase-in period. The goal is 100 percent enrollment of all Colorado medical assistance recipients, but flexibility is given to the department to make recommendations to the General Assembly regarding populations that should be exempt from managed care enrollment. The bill also creates a medical assistance consumer choice pilot program for certain medical assistance recipients with low-risk medical conditions to be implemented no later than January 1, 1997, and continuing at least three years.

COMMITTEE REPORT

Statutory Authority and Responsibilities

Section 26-4-702, C.R.S., enacted by Senate Bill 93-122, requires the General Assembly to consider legislation before July 1, 1996, that would provide an alternative medical assistance program to poor persons in the state. This law directs the Office of State Planning and Budgeting (OSPB) to develop such a program in consultation with other state agencies. The General Assembly may adopt a plan submitted by OSPB or adopt any other alternative plan designed to reduce the state's cost in participating in the federal Medicaid program.

The State Medical Assistance Reform Advisory Committee was established by Senate Bill 93-122 (Section 26-4-704, C.R.S.) to review and provide ideas on the development of an alternative medical assistance program for the state. The committee comprises fourteen members: four legislative members, and ten members representing vendors who participate in the medical assistance program, consumers under the medical assistance program or consumer advocates, and members of the general public. Three of the non-legislative members are appointed jointly by the Speaker of the House of Representatives and the President of the Senate, and seven are appointed by the Governor.

Under its mandate from Senate Bill 93-122, OSPB studied 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 Colorado. The Colorado Medicaid Reform Study of September 1993, considered the effects on access to and expenditures for Medicaid if changes were made in eligibility, benefits, provider reimbursement, and in some cost-savings strategies. The March 1995 Colorado Medicaid Reform Study: Phase II, Long-term Care focused on both long-term care services and programs, as well as on services provided by the Medicaid program to persons with mental illness. In April of 1995, OSPB submitted an alternative Medicaid plan based largely on two studies conducted by the University of Colorado Health Sciences Center.[1] These studies were initiated partially at the direction of the Governor in response to a veto of Senate Bill 92-65, which would have repealed the Colorado Medicaid Assistance Act, resulting in a potential loss of substantial federal funds for the medical assistance program.

Committee Activities and Recommendation

Meeting almost monthly since October 1993 through March of 1995, the committee recognized that Colorado must make significant changes to its Medicaid program in order to meet proposed federal budget reductions and rising state expenditures. Given the charge to offer an alternative plan designed to reduce the

state's cost in participating in the federal Medicaid program, the committee expressed a preference to change the Medicaid system.

The committee held four meetings during the summer and fall of 1995. A committee sub-group explored the possibility of managed care for certain Medicaid recipients and the use of consumer certificates of choice. The sub-group's findings were discussed by the entire Advisory Committee, which concluded that the structure, as well as the administration of the Medicaid program should be changed and that continuing with the current program is unacceptable.

The committee received a briefing from the Joint Budget Committee Staff on congressional budget action, including its possible impact on Colorado, and an analysis of the optional services provided under the Colorado Medicaid program. The experience of other states indicates that reactive, rapid, and comprehensive changes to a state's medical assistance program are costly and inefficient. Cost-efficient reforms to the Medicaid program were discussed, including managed care, capitated managed care, the use of primary care physicians, copayments, and managed care programs for the elderly.

The committee recommends that Colorado implement a statewide phased-in, 100 percent enrollment managed care system for medical assistance recipients and a pilot program for a consumer certificate of choice. These two changes provide an opportunity to adopt an innovative and cost-efficient state medical assistance strategy for meeting the medical needs of those reliant on the program. On the basis of these activities and the OSPB studies, Bill A was recommended for consideration in the 1996 legislative session.

Overview of Medicaid Program

Authorized in 1964 under Title XIX of the Social Security Act, the Medicaid program is a joint federal-state program which provides care to certain low-income individuals, including individuals with disabilities and the elderly. Colorado implemented its Medicaid program in 1969, and it is currently administered by the Department of Health Care Policy and Financing. As a financially shared program with the federal government, states must comply with certain federal requirements but have some latitude to shape the program to meet state needs, such as optional services.

Compared with other states, Colorado has a lean Medicaid program, with relatively few optional programs. Individuals in the program receive a broad array of acute and long- term care services, including institutional care and home- and community-based services. However, the federal Medicaid program does not adequately address the needs of all impoverished Colorado citizens. As a result, other state funded programs have been implemented to address the needs of the poor, such as the Children's Health Plan and the Medically Indigent Program.

Expenditures for Medicaid grew considerably in recent years. These increased costs were driven by federal mandates that expand the number of people the states must cover and the number of services provided; rising medical expenses; expensive new medical technologies; provider reimbursement for services; more people enrolled in the program in accordance with eligibility criteria; increased utilization; and litigation. Also, the inflation rate for medical care rose faster than the general inflation rate in recent years.

Eligibility. Eligibility for providing Medicaid services in Colorado is linked to receipt of cash assistance from one of two public assistance programs, Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI), or results from federal expansions of eligibility to groups such as low income pregnant women. Under Medicaid rules, some eligibility categories are required by federal law and some are at state option. The same is also true for services; some are mandatory, while others are optional. At present, approximately 10 percent of Colorado's population receives health care paid for by the Medicaid program at some point during the year. Medicaid currently serves approximately 290,000 eligible clients, accounting for 17 percent of the General Fund budget.

Expenditures. Total Medicaid expenditures in FY 1995-96 are estimated to be $1.4 billion. Medicaid expenditures account for about 10 percent of the state's health care expenditures. Meanwhile, 34 percent of births in Colorado are funded by Medicaid. Costs per recipient are projected to average $3,413 in FY 1995-96. Medicaid reimburses providers for physician services, hospital care, prescriptions, nursing facility and home health care, and other health care services when medically necessary. Colorado pays 48 percent of the costs, and the federal government pays 52 percent.

While children constitute 50 percent of the Medicaid population, they account for less than 18 percent of total program expenditures. In contrast, the disabled and those over age 65 comprise less than 28 percent of the Medicaid population, but account for 70 percent of total expenditures. Three of the most costly services are inpatient hospital services, physician services, and nursing home services.

Medicaid Caseload

Year	Caseload	Change
FY 1992	242,881	
FY 1993	268,170	10.4%
FY 1994	281,696	5.0%
FY 1995	284,009	0.8%
FY 1996	294,207	3.6%
FY 1997	310,110	5.4%
FY 1998	324,071	4.5%

SOURCE: Legislative Council Staff.

Services. Optional Medicaid programs — both populations and services — account for $773.9 million, or 53 percent, of the approximately $1.4 billion total Medicaid expenditures expected in FY 1995-96.[2] Conversely, mandated programs account for $672.4 million, or 46.5 percent, of Colorado Medicaid spending. Of this latter amount, $315.3 million is funded from state general funds, and $357.1 million is funded with federal funds.

Mandated services are Class I nursing homes, county transportation, home health care, physicians care, inpatient-outpatient hospital care, family planning, early periodic screening diagnosis and treatment (EPSDT), lab and X-ray services, federally qualified health centers, durable medical equipment, emergency transportation, supplemental Medicare insurance premiums, Medicare coinsurance and deductibles, health insurance buy-in, and immunizations for children.

Colorado has opted to provide the following non-federally mandated benefits: Class II/IV nursing homes, nursing home incentive allowance, hospice, prescription drugs, under age 21 psychiatric care, single entry point, residential treatment centers, podiatry, optometry, enhanced prenatal care, health maintenance organizations, home- and community-based services for the elderly, blind and disabled and persons living with AIDS, private duty nursing, the program for All Inclusive Care for the Elderly, Katie Beckett/Model 200 waiver, disproportionate share payments, physician incentive pool within the Primary Care Physician (PCP) program, and high-risk pregnant women's program.

Optional services all have a benefit to the state in some fashion. For example, optional programs such as prescription drugs help to keep down costs of mandated programs, such as inpatient-outpatient hospitalization, which would most likely increase

without this service. Colorado also administers the Medicaid Disproportionate Share Hospital (DSH) Program, where additional payments are made to hospitals that serve a disproportionately large number of Medicaid and uninsured individuals. Disproportionate share payments benefit state and hospital revenue and relieve uncompensated hospitalization utilization.

Federal budget reductions. The most significant changes in the Medicaid program since its inception are likely to occur at the federal level this fiscal year. The federal government may choose to provide funding for state medical assistance programs to low-income people through federal block grants, known as the Medigrant Program. The proposal may require states to provide services to three categories of low-income people: families and children, blind or disabled adults under age 65, and people 65 or older. Each state could be allotted a maximum amount based on its total expenditures for a particular federal fiscal year. If federal financial participation is reduced through this program without making any corresponding changes to federal requirements, Colorado may be in a position of determining what populations may be served in the most cost-efficient manner.

Reductions in the Medicaid program at the federal level could result in a significant shortfall of federal funds to Colorado by 2001. By resolution, Congress has agreed to reduce the rate of national growth of Medicaid spending to 7.2 percent in federal fiscal year 1996, 6.8 percent in federal fiscal year 1997, and 4 percent for each of the next five years. This reduction results in a seven-year national budget savings of $181.6 billion. The state-by-state distribution of federal money ($182 billion), the program structure, the amount of state flexibility, and whether to require any maintenance of effort would be determined at a later date. Under the present Congressional House Medigrant proposal, Colorado is estimated to lose $1.3 billion in federal funds over the next seven years.[3]

Medicaid Managed Care

With respect to specific populations, Colorado has been and is involved in various cost-efficient reforms to the state medical assistance program. These reforms include, but are not limited to, managed care, capitated managed care, the use of primary care physicians, copayments, and managed programs for the elderly such as the Program of All-Inclusive Care for the Elderly (PACE). One way of containing costs of Medicaid is through managed care, which addresses cost and utilization control and may save money by lowering hospitalization utilization rates. The alternative plan submitted to the General Assembly by the Office of State Planning and Budgeting concluded that managed care offers the best opportunity for the state to control hospital expenditures and to expand the provision of primary care. Basically, managed care delivery systems are designed to manage a person's utilization of services to ensure that only necessary services are consumed.

Managed care combines quality of care assurance and cost control by providing continuity of care and access to timely and necessary care, while at the same time limiting access to care that is not needed or that is more expensive than necessary. Managed care organizations (MCO) provide cost-efficient and appropriate services with the purpose of encouraging and allowing consumers to maintain good health. A benefit of managed care is that it provides some predictability for expenditures. Some states have a single department or agency administer the entire managed care program. A 100 percent statewide managed care system under current law would require a federal waiver.

The Department of Health Care Policy and Financing is moving forward on a voluntary basis toward managed care. The department is researching quality assurance methods, including the Health Employer Data Information Set (HEDIS) for the managed care system. Quality of care standards should appropriately measure care of all enrolled recipients. Currently, the Colorado Medicaid program has established a system of managed care under which Medicaid clients select a primary care provider upon enrollment, either a primary care physician (PCP) or a health maintenance organization (HMO). The PCP or HMO provider delivers primary care, manages the individual's care, and controls access to more specialized care providers. There are approximately 98,000 Medicaid clients involved with PCPs, and 41,200 Medicaid recipients are enrolled in managed care through 8 health care provider (HMO/PHP) plans. This is approximately 48 percent of the total number of Medicaid beneficiaries.

Managed care services for the provision of mental health under Medicaid are now capitated on a pilot basis under state law. Over 161,000 recipients are enrolled through the seven mental health assessment and service agencies of the Colorado Medicaid Mental Health Capitation and Managed Care Program. Fifty-one of Colorado's 63 counties participate in this program.

The low cost medical assistance recipients are AFDC baby care-kid care children and adults. The department indicated that more managed care organizations are interested in doing business with the state to serve these clients. The committee explored the need to increase Medicaid enrollment in existing HMOs for AFDC baby care-kid care children and adults, and foster care children.

The elderly and disabled are relatively high cost populations under Medicaid, and these populations should not be excluded from managed care participation. Some elderly are involved in Medicaid managed care but not to the degree of other populations. A pilot project to study the integration of acute and long-term care for the elderly, the Integrated Care and Financing Project, is now underway. Funded by a grant from the Robert Wood Johnson Foundation, the project is overseen by the department.

Medicaid Consumer Choice Certificate

Medicaid clients have an interest in knowing what health care options are available and how they differ from each other, how managed care works to meet their health care needs, and how to exercise the highest degree of personal choice over their own care. To this end, the Advisory Committee proposes the use of a capitated certificate of enrollment, while allowing for voluntary participation but creating disincentives for nonparticipation. Eligible consumers who choose not to participate would be required to pay a minimum copayment for services established by the Medical Services Board. A capitated certificate of enrollment would be provided directly to a consumer or to a consumer's payee for the purpose of allowing the consumer to choose an MCO to provide health care coverage.

Providers would be selected by the department upon assurance of compliance with specific criteria, such as educational components to the plan, data collection and reporting requirements, consumer incentives, minimum benefit requirements, solvency, client surveys, and departmental utilization requirements. The educational component serves a dual function: 1) to educate consumers on the availability of the plan; and 2) to educate consumers concerning the use of the medical services system, such as preventive care.

The committee concluded that incentives are needed for Medicaid consumers to make informed health care decisions. A number of incentives would be offered to eligible consumers, such as inclusion of consumers on applicable decision-making boards, co-pay of ownership of durable medical equipment, recognition of the need for improved health; health care outcomes, and receipt of medical disposable supplies without charge. Incentives also include permitting a consumer to retain a portion of the savings resulting from the consumer's selection of a medical plan at a rate that is lower than the value of the certificate.

Consumer involvement and education in choice of health care is important in providing a degree of empowerment to those recipients of the medical assistance program. For clients in managed care to exercise genuine choice of services and providers, extensive educational outreach and complete, unbiased information must be available. If low-income consumers are to have the right to choose the best managed care plan for their needs, standards must be formulated that protect against bias, misinformation, and high-pressure solicitation.

The Department of Health Care Policy and Financing has developed a proposed state marketing plan for Colorado Medicaid Managed Care. The goal of the marketing plan is to closely monitor plans and to counsel Medicaid beneficiaries around managed care principles and options that facilitate enrollment with health plans, avoid risk selection, and meet the clients' health care needs in a cost effective way.

Summary of Recommendation

The committee recommends the following bill to the Colorado General Assembly.

Bill A — Adjustments to State Medical Assistance Programs

Statewide Managed Care System

Bill A requires the Department of Health Care Policy and Financing to establish a statewide managed care system over a three-year phase-in period, conditioned upon federal waivers. Managed care for the entire medical assistance population would occur statewide by July 1, 1999. The managed care project only applies to persons eligible for medical assistance. Participants shall be medical assistance recipients enrolled in a Health Maintenance Organization (HMO), excluding persons with developmental disabilities and persons with need of mental health services. These two populations will continue to receive services under the applicable system for those populations.

Phase I. All managed care demonstration programs or managed care for limited populations in effect July 1, 1996 become statewide July 1, 1999, unless repealed by the General Assembly before that date. Managed care programs include the Integrated Care and Financing Project funded by the Robert Wood Johnson Foundation to study the integration of acute and long-term care. Other programs that become part of the statewide managed care system are managed care contracts (limited enrollment in managed care for medical assistance recipients in Mesa county, Pueblo county, and the Denver Metropolitan area), managed mental health services, the Program of All-Inclusive Care for the Elderly (PACE), and the consumer choice pilot program.

The bill requires the Integrated Care and Financing Project to be conducted in a county selected by the department. That county will have long-term experience in providing managed care for the medical assistance population and have a system for managing long-term care, including referral to appropriate services, care planning, and brokering and monitoring of services.

Acute and long-term care. Under Bill A, acute and long-term care for the elderly are combined 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. Health services must include the basic services provided to the private sector served by an HMO in addition to the services provided under the long-term care managed system. The Integrated Care and Financing Project must adopt

the following goals: *ensure* that integrated acute and long-term care managed care does not result in inadequate access to and quality of health care; *assure* client satisfaction and improved client health status; and provide a sufficient *collection* of health data and client outcomes.

HMOs would be required to establish a complaint process for participants dissatisfied with the care provided by them. Procedures would also be adopted to allow a participant to disenroll from the project and continue eligibility under the medical assistance program. Random surveys would be conducted by the department to assess client satisfaction.

Phase II. Managed care for Medicaid recipients residing in metropolitan areas of the state shall be implemented statewide no later than July 1, 1998, unless specific populations of recipients are exempt or enrollment into managed care is postponed.

Phase III. Managed care for Medicaid recipients residing in rural areas of the state shall be implemented statewide no later than July 1, 1999, unless specific populations of recipients are exempt or enrollment into managed care is postponed.

Department recommendations — administrative rules. Under Bill A, the department is allowed to explore various methods of providing managed care for certain medicial assistance populations. These methods may range from unique managed care contracts with special reimbursment arrangements to specific providers or services. In order to give the department flexibility during the phase-in period, annual recommendations will be made to the General Assembly with respect to necessary exemptions from the requirement that managed care be implemented for 100 percent of the Medicaid population on a statewide basis. The department is required to eliminate administrative rules and functions that are unnecessary and unrelated to the implementation of the statewide managed care system. Recommendations from managed care providers and health care coverage cooperatives are to be considered in eliminating unnecessary and unrelated rules and functions.

Privatization. The private sector has extensive experience in managed health care. A statewide managed care system involves duties similar to those currently or previously performed by state employees but is different in scope and policy objectives from the state medical assistance program. Under the provisions of the bill, the department is required to enter into personal services contracts that create an independent contractor relationship for the administration of a certain percentage of the statewide managed care system. The department is also required to enter into personal service contracts for the administration of the managed care system according to the schedule for implementing the statewide managed care system.

The department will make recommendations concerning privatization of the administration of the managed care system in its annual report; however, any implementation will be contingent upon a finding by the Joint Budget Committee that privatization of the managed care system is cost-efficient. The privatization component

must also meet a finding by the state personnel director that the conditions imposed on the use of private contractors for personnel services by the state personnel system are met.

Data collection. The bill mandates data collection and reporting requirements for providers and managed care organizations serving Medicaid clients under existing expansion plans or under the pilot program. The department must access and compile data submitted by providers or managed care organizations participating in any managed care plan. An annual report using the compiled data on the cost-efficiency of each managed care plan is to be submitted to the General Assembly with recommendations concerning statewide implementation. Cost-efficiency 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 report will address capitation, fees-for-services, copayments, chronically ill populations, long-term care, community-supported services, and the entitlement status of medical assistance. In addition, the department, after obtaining and considering consumer input, will make recommendations and provide a plan for implementation concerning the feasibility of managed care systems for the developmentally disabled population and for long-term care.

Requirements of provider or managed care organization. Bill A places a number of service requirements for providers and MCOs participating in the statewide managed care program, plan, or component. Each provider or managed care organization must submit the following types of data to the system for access by the state department: 1) medical access; 2) consumer outcomes based on statistics maintained on individual consumers as well as on the total population of consumers; 3) consumer satisfaction; 4) consumer utilization; and 5) consumer health maintenance status.

Medical Assistance Consumer Choice Program

Bill A creates a consumer choice pilot program for medical assistance recipients with low-risk medical conditions — AFDC recipients, women, and children. The program would be implemented no later than January 1, 1997, and would continue for at least three years. Rural and urban counties would be selected by the department to participate in the pilot program, one of which would have a population of 100,000 more and one of which would have a population of less than 100,000.

The department will seek a waiver from the federal government to develop and implement a medical assistance consumer choice program on a pilot basis. Appropriate staff training, policy development, and rule-making will help prepare the department for this pilot program. The Medical Services Board will promulgate rules regulating the appropriate educational tools to be used by health coverage cooperatives and MCOs for the consumer choice program.

Program features include: 1) marketing systems that encourage the participation of MCOs and consumers, including the use of health care coverage cooperatives; and 2) eligible consumers from a participating county who volunteer to participate. Eligible consumers who choose not to participate would be required to pay a minimum copayment for services established by Medical Services Board program.

A number of incentives would be offered to eligible consumers, such as inclusion of a consumer on the Medical Services Board, copay ownership of durable medical equipment, recognition for improved health status outcomes, and receipt of medical disposable supplies without charge. Incentives also include permitting a consumer to retain a portion of the savings resulting from the consumers' selection of a medical plan at a rate that is lower than the value of the voucher for a purpose related to delivery of a public service. The department would solicit partnerships with local governments and the private sector to develop these incentives.

A capitated certificate of enrollment would be provided directly to a consumer or a consumer's representative in order to allow the consumer to choose an MCO to provide health care coverage. The consumer may use a health care coverage cooperative to select an MCO. This certificate would be presented for reimbursement to the state department or to the entity responsible for administering payments for health care coverage plans, but may not be used to directly purchase any health care service.

Assurances by managed care organizations. In order to participate in the pilot program, certain criteria and assurances of compliance must be met by the managed care organizations in their plans. MCOs must give assurance of the following:

- all eligible consumers will be accepted regardless of health status, except that the value of the certificate shall be reflective of their health status;

- pregnant women will be enrolled without restrictions, and the health care provider will provide pre-natal care to pregnant woman within two weeks after enrollment;

- newborns will be covered without restrictions, including services such as preventive care and screening and well-baby exams during the first month of life;

- performance standards will be imposed and quality indicators will be used with respect to perinatal, pre-natal, and postpartum care for women and birthing and neonatal care for infants;

- follow-up basic health maintenance services will be provided for women and children, including immunizations, EPSDT, pap smears for women;

- an educational component in the MCO plan will be developed with consumer input that shall inform consumers as to the availability of

plans, use of the medical service system, use of appropriate preventive health care procedures, self-care, and appropriate health care utilization;

- minimum benefit requirements will be provided, including preventive care, pharmaceuticals, durable medical equipment, chronic care, and acute care;

- no interference will occur with appropriate medical care decisions rendered by the provider;

- payments will be made to providers within a commercially reasonable time;

- appropriate use of ancillary health care providers such as physical therapists, occupational therapists, speech pathologists, and nurse practitioners;

- necessary and appropriate services will be provided to consumers;

- MCOs will remain solvent through a bonding process established by the Medical Services Board;

- adherence to utilization standards, data collection, and reporting requirements;

- consumer incentives will be incorporated and used;

- a form or process will be implemented for measuring group and individual consumer health outcomes and the use of tools such as client surveys or methods that identify increased health maintenance, determine the degree of medical access, and reveal consumer satisfaction and habits;

- allowances for a consumer to change MCOs for good cause as established by the board will be included;

- no premiums or other inducements would be provided to a recipient in exchange for the recipient selecting the MCO for coverage;

- a grievance procedure would provide for the timely resolution of disputes regarding the quality of care, services to be provided, and other issues raised by the recipient;

- the measurement of consumer outcomes, including but not limited to the use of client surveys, and the use of tools and systems for identifying increased health maintenance, and increased use of outpatient services balanced with a decrease in emergency room use and inpatient services.

Bill A requires an MCO to submit annually 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. Systematic evaluations of the MCOs and health care providers will be performed. The purpose of the evaluations is to determine whether an MCO or provider has the capacity to serve special needs of the participants in the pilot program.

Pilot program rules. The board would adopt rules concerning the pilot program to include the following:

- criteria for the selection of participating counties;
- copayments to be paid by eligible consumers who choose not to participate in the pilot program;
- the capitated amount to be paid to or on behalf of consumers;
- criteria for the selection of MCOs that may participate in the program;
- bonding requirements for MCOs;
- additional requirements for health care coverage cooperatives, which requirements shall relate to serving the medical assistance population participating in the pilot program;
- the form and amount of MCO and consumer incentives for participating in the pilot program;
- a definition of "good cause" as the basis for allowing consumers to change MCOs;
- a process for recovering the capitated payment made to or on behalf of a consumer who changes MCOs for good cause or for paying for services rendered by the new MCO;
- a process by which the department or an agency acting for the department performs systematic evaluations to the MCOs and health care providers;
- a procedure under which individual participants may disenroll from an individual health care plan and from the pilot program, but continue eligibility under the medical assistance program;

- a procedure for transferring consumers from one health coverage plan to another in the event a health care coverage plan administrator is eliminated from the program;

- appropriate educational and marketing tools to be implemented by health coverage cooperatives and MCOs; and

- MCO sanctions for failing to comply with utilization, data collection, and reporting requirements for consumer dissatisfaction.

The department will submit a report to the General Assembly as to the provisions that have been approved by federal waiver and would recommend legislation that conforms with the waiver provisions no later than the next regular legislative session following issuance of the waiver. The department will provide written notice to the revisor of the date specified in the waiver.

Upon expiration of the pilot program, the department will make recommendations to the General Assembly on the feasibility of a statewide capitated managed care medical assistance program. These recommendations would 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 entitlements.

Materials Available

The materials listed below are available upon request from the Legislative Council staff.

Legislative Council Staff Meeting Summaries

Summaries of 1995 State Medical Assistance Reform Advisory Committee meetings held on July 11, September 8, October 3, and October 13.

Joint Budget Committee Staff Analyses

Joint Budget Committee Staff Analysis: Optional Medicaid Programs. September 8, 1995.

Joint Budget Committee Staff Analysis of House Energy and Commerce Committee Action on Medicaid - The Medigrant Proposal. October 2, 1995.

Reports

Barton, P., Bondy, J., Byrnes, P., and Glazner, J., (1993). *Final Report: Colorado Medicaid Reform Study.* Denver, CO. University of Colorado Health Sciences Center.

Barton, P., Glazner, J., and Poole, C. (1995). *Final Report: Colorado Medicaid Reform Study, Phase II, Long-term Care.* Denver, CO. University of Colorado Health Sciences Center.

Barton, P., Glazner, J., and Poole, C. (1995). *Colorado Medicaid Reform Study. A Summary Report.* Denver, CO. University of Colorado Health Sciences Center and the Office of State Planning and Budgeting. This report summarizes the findings and recommendations from the two reports listed above.

ENDNOTES

1. Barton, P., Glazner, J., and Poole, C. (1995). *Colorado Medicaid Reform Study. A Summary Report.* Denver, CO. University of Colorado Health Sciences Center and the Office of State Planning and Budgeting.

2. Joint Budget Committee Staff Analysis: Optional Medicaid Program. September 8, 1995. Page 2.

3. Joint Budget Committee Staff Analysis of House Energy and Commerce Committee Action on Medicaid — The Medigrant Proposal. October 2, 1995.

BILL A

A BILL FOR AN ACT

CONCERNING ADJUSTMENTS TO STATE MEDICAL ASSISTANCE PROGRAMS.

Bill Summary

"Medical Assistance Changes"

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

Medicaid Advisory Committee.

1. **Legislative declaration.** (§26-4-112, pp. 4-6) Describes the historical impact of federal medicaid requirements on this state and the opportunity Colorado has to tailor the medical assistance program from the state's perspective.

2. **Statewide Managed Care System.** (§26-4-113, pp. 6-12) Requires the department of health care policy and financing to establish a statewide managed care system over a 3-year phase-in period. Establishes the goal of 100% enrollment of medical assistance recipients, with flexibility given to the department to make recommendations to the general assembly regarding populations that should be exempt from managed care enrollment.

Describes the phase-in period, as follows:

* Phase I (See §26-4-113 (2)(a), pp. 7-9) All managed care demonstration programs or managed care for limited populations in effect July 1, 1996, become statewide July 1, 1999, unless repealed by the general assembly before that date;

* Phase II (See §26-4-113 (2)(b), p. 9) Managed care is implemented for medical assistance recipients residing in metropolitan areas of the state no later than July 1, 1998, unless by statute specific population of medical assistance recipients in those areas of the state are otherwise exempt or enrollment into managed care for those populations is postponed;

* Phase III (See §26-4-113 (2)(c), p. 10) Managed care is implemented for medical assistance recipients residing in rural areas no later than July 1, 1999, unless by statute specific population of medical assistance recipients in those areas of the state are otherwise exempt or enrollment into managed care for those populations is postponed.

3. **Administrative Rules and Privatization.** (§26-4-113 (4) and (5), pp. 10-12) Requires a phase-out of unnecessary and burdensome administrative rules and functions and a phase-in of administrative privatization of managed care, both of which are connected to the phase-in period for statewide managed care.

4. **Data Collection.** (§26-4-114, pp. 12-14) Sets forth data collection and reporting requirements for managed care, capitated, or capitated managed care programs that serv medical assistance recipients. Requires providers and MCO's to use a nationally approved system for compiling and maintaining health data information. Directs the department of health care policy and financing to submit reports to the general assembly using data maintained by the nationally approved system.

5. **Consumer Choice Program.** (§26-4-117, pp. 24-34) Creates a 3-year medical assistance consumer choice pilot program for certain medical assistance recipients with low-risk medical conditions. Describes components of the program as follows:

* A voluntary population that consists primarily of women and children from rural and urban sites selected by the department of health care policy and financing.
* Marketing systems that encourage the participation of managed care organizations (MCO's) and consumers, including but not limited to the use of health purchasing cooperatives
* Selection of MCO's by the department of health care policy and financing based on criteria established by the medical services board
* MCO incentives in connection with consumer utilization and health maintenance

Relocates existing statutory provisions and programs, as follows:

1. **Managed Mental Health.** (§26-4-115, pp. 14-19)

2. **Purchase Access Care for the Elderly.** (also referred to as "ON LOK" or "PACE" - §26-4-116, pp. 19-24)

Codifies administratively created managed care features or programs:

1. **Integrated acute and long-term care.** (§26-4-113 (2)(a)(I), pp. 7-9) Codifies an administratively created project to study the integration of acute and long-term care using medicare and medicaid financing for medical assistance recipients who are eligible for both federal programs.

Makes conforming amendments to provisions governing health care coverage cooperatives in connection with the role the cooperatives will play with respect to the medical assistance program.

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 THE FOLLOWING NEW SECTIONS CONTAINING RELOCATED PROVISIONS, WITH AMENDMENTS, to read:

SUBPART 1

GENERAL PROVISIONS

26-4-101.5. Short title - citation. THIS SUBPART 1 SHALL BE COMPRISED 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".

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

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

SUBPART 2

STATEWIDE MANAGED CARE SYSTEM

26-4-111. Short title - citation. THIS SUBPART 2 SHALL BE COMPRISED OF SECTIONS 26-4-111 TO 26-4-125 AND MAY BE CITED AS SUBPART 2. THE TITLE OF THIS SUBPART 2 SHALL BE KNOWN AND MAY BE CITED AS "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 COLORADO CHILDREN'S HEALTH PLAN, ARTICLE 17 OF THIS TITLE, AND THE REFORM ACT FOR THE PROVISION OF 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 BE IN A POSITION OF DETERMINING WHAT 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; AND

(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.

(2) THE GENERAL ASSEMBLY FURTHER FINDS THAT WITH RECOMMENDATIONS FROM THE MEDICAL ASSISTANCE REFORM ADVISORY COMMITTEE CREATED IN SECTION 26-4-705, 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, ON THE BASIS OF THE STUDY AND FURTHER RECOMMENDATIONS BY THE MEDICAL ASSISTANCE REFORM ADVISORY COMMITTEE, IT IS IN THE STATE'S BEST INTEREST TO ADOPT THIS SUBPART 2.

26-4-113. Statewide managed care system - implementation required - phases - administration - privatization - legislative intent. (1) **Rules.** THE STATE DEPARTMENT SHALL ADOPT RULES TO IMPLEMENT A MANAGED CARE SYSTEM FOR ONE HUNDRED PERCENT OF THE COLORADO MEDICAL ASSISTANCE POPULATION ON A STATEWIDE BASIS PURSUANT TO THE PROVISIONS OF THIS

ARTICLE. THE RULES SHALL INCLUDE A PLAN TO PHASE-IN THE STATEWIDE MANAGED CARE SYSTEM OVER A THREE-YEAR PHASE-IN PERIOD PURSUANT TO THE PROVISIONS OF SUBSECTION (2) OF THIS SECTION.

(2) **Statewide managed care - phased-in implementation.** (a) **Phase I.** ALL MANAGED CARE PROGRAMS, WHETHER THE PROGRAM IS A PILOT PROJECT OR IS IN EFFECT JULY 1, 1996, SHALL BE IMPLEMENTED ON A STATEWIDE BASIS NO LATER THAN JULY 1, 1999, UNLESS OTHERWISE REPEALED BY THE GENERAL ASSEMBLY BEFORE THAT DATE. MANAGED CARE PILOT PROGRAMS OR CONTRACTS IN EFFECT JULY 1, 1996, 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, WHICH PILOT PROJECT THE STATE DEPARTMENT IS AUTHORIZED TO OVERSEE AND WHICH SHALL BE ADMINISTERED WITHIN THE FOLLOWING GUIDELINES:

(A) THE PROJECT SHALL BE CONDUCTED IN A COUNTY SELECTED BY THE STATE DEPARTMENT, WHICH COUNTY 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: ENSURE THAT 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.

(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 26-4-115;

(IV) **Elderly.** PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY, AS DESCRIBED IN SECTION 26-4-116;

(V) **Consumer choice.** THE CONSUMER CHOICE PILOT PROGRAM, AS DESCRIBED IN SECTION 26-4-117, SO LONG AS THE NECESSARY WAIVERS ARE GRANTED TO THE STATE BY THE FEDERAL HEALTH CARE FINANCING ADMINISTRATION.

(b) **Phase II.** MANAGED CARE FOR MEDICAL ASSISTANCE RECIPIENTS RESIDING IN METROPOLITAN AREAS OF THE STATE SHALL BE IMPLEMENTED STATEWIDE NO LATER THAN JULY 1, 1998, UNLESS BY STATUTE SPECIFIC POPULATIONS OF MEDICAL ASSISTANCE RECIPIENTS ARE OTHERWISE EXEMPT OR ENROLLMENT INTO MANAGED CARE FOR SUCH POPULATIONS IS POSTPONED;

(c) **Phase III.** MANAGED CARE FOR MEDICAL ASSISTANCE RECIPIENTS RESIDING IN RURAL AREAS OF THE STATE SHALL BE IMPLEMENTED STATEWIDE NO LATER THAN JULY 1, 1999, UNLESS BY STATUTE SPECIFIC POPULATIONS OF MEDICAL ASSISTANCE RECIPIENTS ARE OTHERWISE EXEMPT OF ENROLLMENT INTO MANAGED CARE FOR SUCH POPULATIONS IS POSTPONED.

(3) **State department recommendations.** IT IS THE GENERAL ASSEMBLY'S INTENT THAT THE STATE OF COLORADO HAVE A STATEWIDE MANAGED CARE SYSTEM FOR MEDICAL ASSISTANCE RECIPIENTS WITH ONE HUNDRED 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 FOR EACH FISCAL YEAR OF THE PHASE-IN PERIOD PROVIDED IN SUBSECTION (2) OF THIS SECTION, THE STATE DEPARTMENT SHALL MAKE RECOMMENDATIONS TO THE GENERAL ASSEMBLY WITH RESPECT TO NECESSARY EXEMPTIONS FROM THE REQUIREMENT THAT MANAGED CARE BE IMPLEMENTED FOR ONE HUNDRED PERCENT OF THE MEDICAL ASSISTANCE POPULATION ON A STATEWIDE BASIS NO LATER THAN JULY 1, 1999.

(4) **State department - rules.** IT IS THE GENERAL ASSEMBLY'S FURTHER 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 FOLLOW RECOMMENDATIONS FROM MANAGED CARE PROVIDERS, HEALTH CARE COVERAGE COOPERATIVES,

AND THE MEDICAL ASSISTANCE ADVISORY COMMITTEE IN ELIMINATING UNNECESSARY AND UNRELATED RULES AND FUNCTIONS.

(5) **State department - privatization.** (a) 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.

(b) 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 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 SCHEDULE FOR IMPLEMENTING THE STATEWIDE MANAGED CARE SYSTEM IN ACCORDANCE WITH SUBSECTION (2) OF THIS SECTION.

(c) IN CONNECTION WITH THE REQUIREMENT SET FORTH IN PARAGRAPH (b) OF THIS SUBSECTION (5), THE STATE DEPARTMENT SHALL INCLUDE RECOMMENDATIONS CONCERNING PRIVATIZATION OF THE ADMINISTRATION OF THE MANAGED CARE SYSTEM IN ITS ANNUAL REPORT REQUIRED BY SUBSECTION (3) OF THIS SECTION.

(d) THE IMPLEMENTATION OF THIS SUBSECTION (5) 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 SHALL BE IMPLEMENTED ONLY TO THE EXTENT THAT PRIVATIZATION IS COST-EFFICIENT. IN ADDITION, THE IMPLEMENTATION OF THIS SUBSECTION (5) 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 ALL OF THE CONDITIONS OF 24-50-503 (1), C.R.S., HAVE BEEN MET.

(6) 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.

26-4-114. Data collection for managed care programs - reports. (1) IN ADDITION TO ANY OTHER DATA COLLECTION OR REPORTING REQUIREMENTS SET FORTH IN THIS ARTICLE, NO LATER THAN THIRTY DAYS AFTER THE DATE THAT NUMBERS FOR A NATIONALLY APPROVED SYSTEM OR METHOD FOR COLLECTING HEALTH DATA INFORMATION FOR PERSONS ENROLLED IN MANAGED CARE, HEREAFTER REFERRED TO AS HDIS OR SYSTEM, ARE ASSIGNED FOR MEDICAL ASSISTANCE RECIPIENTS, THE STATE DEPARTMENT SHALL ACCESS AND COMPILE SUCH DATA. IN ADDITION, NO LATER THAN JULY 1, 1998, THE STATE DEPARTMENT SHALL CONDUCT OR SHALL CONTRACT WITH AN INDEPENDENT EVALUATOR TO CONDUCT A COST-EFFICIENCY 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, 1997, AND EACH FISCAL YEAR THEREAFTER, THE STATE DEPARTMENT USING THE COMPILED DATA AND RESULTS FROM THE COST-EFFICIENCY ANALYSIS SHALL SUBMIT A REPORT TO THE GENERAL ASSEMBLY ON THE COST-EFFICIENCY OF EACH MANAGED CARE PLAN, PROGRAM, OR COMPONENT THEREOF, WITH RECOMMENDATIONS CONCERNING STATEWIDE IMPLEMENTATION OF THE RESPECTIVE PLANS, PROGRAMS, OR COMPONENTS. FOR THE PURPOSES OF THIS SUBSECTION (1), THE TERM "COST-EFFICIENCY" 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 SHALL OBTAIN AND CONSIDER CONSUMER INPUT AND MAKE RECOMMENDATIONS CONCERNING THE FEASIBILITY OF IMPLEMENTING MANAGED CARE SYSTEMS FOR THE DEVELOPMENTALLY DISABLED POPULATION AND FOR LONG-TERM CARE, WHICH RECOMMENDATION SHALL INCLUDE A PLAN FOR IMPLEMENTATION.

(3) NO LATER THAN THIRTY DAYS AFTER NUMBERS FOR MEDICAL ASSISTANCE RECIPIENTS ARE ASSIGNED FOR THE SYSTEM, 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 MAINTENANCE STATUS OF CONSUMERS.

26-4-115. Managed mental health services feasibility study - waiver - pilot program. [Formerly 26-4-528.] (1) (a) The STATE department ~~of health care policy and financing~~ and the department of human services shall jointly conduct a feasibility study concerning management of mental health services under the "Colorado Medical Assistance Act", which study shall consider a prepaid capitated system for providing comprehensive mental health services. In conducting the study, the STATE department ~~of health care policy and financing~~ and the department of human services shall:

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

(II) 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) On or before October 1, 1992, the state department and the department of human services shall provide a written report to the general assembly assessing the costs, benefits, risks, alternatives, and impact upon recipients, providers, and mental health services in this state, for each model or proposed program modification. Said report shall include recommendations for implementation of any model or proposed program modification.

(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 general assembly 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 general assembly 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.

(5) 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) of this section and to enact this subsection (5) and subsections (6) to (9) of this section.

(6) 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) 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) of this section.

(8) No later than May 1, 1997, or sixty days after receipt of the necessary federal waivers described in subsections (6) and (7) 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) The implementation of this subsection (9) and subsections (5) to (8) 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.

26-4-116. Program of all-inclusive care for the elderly - services - eligibility. [Formerly 26-4-519.] (1) The general assembly hereby finds and declares that it is the intent of this section to replicate the ON LOK program in San Francisco, California, that has proven to be cost-effective at both the state and federal levels. The PACE program is part of a national replication project authorized in section 9412(b)(2) of the federal "Omnibus Budget Reconciliation Act of 1986", as amended, which instructs the secretary of the federal department of health and human services to grant medicare and medicaid waivers to permit not more than ten public or nonprofit private community-based organizations in the country to provide comprehensive health care services on a capitated basis to frail elderly who are at risk of institutionalization. The general assembly finds that, by coordinating an extensive array of medical and nonmedical services, the needs of the participants will be met primarily in an outpatient environment in an adult day health center, in their homes, or in an institutional setting. The general

assembly finds that such a service delivery system will enhance the quality of life for the participant and offers the potential to reduce and cap the costs to Colorado of the medical needs of the participants, including hospital and nursing home admissions.

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(4)~~ (5) An eligible person may elect to receive services from the PACE program as described in subsection (3) 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.)~~

26-4-117. Consumer choice program - pilot authorized - features of program. (1) **Short title.** THIS SECTION SHALL BE KNOWN AND MAY BE CITED AS THE "MEDICAL ASSISTANCE CONSUMER CHOICE PROGRAM".

(2) **Definitions.** AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(a) "CAPITATION" MEANS A SYSTEM OF FINANCIAL REIMBURSEMENT TO MANAGED CARE ORGANIZATIONS, AS DEFINED IN SUBSECTION (7) OF THIS SECTION, PURSUANT TO A CONTRACT BETWEEN THE STATE DEPARTMENT AND THE MANAGED CARE ORGANIZATION UNDER WHICH THE STATE DEPARTMENT MAKES A FIXED PAYMENT TO A MANAGED CARE ORGANIZATION FOR EACH ENROLLEE UNDER A HEALTH BENEFITS PLAN IN EXCHANGE FOR THE MANAGED CARE ORGANIZATION'S DELIVERY OF ALL SERVICES TO ENROLLEES UNDER THE PLAN.

(b) "CONSUMER" MEANS AN ELIGIBLE CONSUMER WHO VOLUNTEERS TO PARTICIPATE IN THE CONSUMER CHOICE PILOT PROGRAM IN A COUNTY SELECTED PURSUANT TO THIS SUBPART 2.

(c) "CONSUMER CHOICE" MEANS A CONSUMER'S ABILITY TO SELECT A MANAGED CARE ORGANIZATION TO MEET THE CONSUMER'S MEDICAL NEEDS WITH A CAPITATED PAYMENT TO OR ON BEHALF OF THE CONSUMER.

(d) "ELIGIBLE CONSUMER" MEANS CHILDREN THROUGH TWENTY YEARS OF AGE AND ADULTS UNDER SIXTY-FIVE YEARS OF AGE DEEMED ELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO THE PROVISIONS OF THIS ARTICLE.

(e) "HEALTH CARE COVERAGE COOPERATIVE" MEANS AN ENTITY AUTHORIZED BY SECTION 6-18-201, C.R.S., AND CERTIFIED IN ACCORDANCE WITH ARTICLE 18 OF TITLE 6, C.R.S., TO PURCHASE HEALTH CARE COVERAGE FOR MEMBERS AND THEIR EMPLOYEES.

(f) "HEALTH CARE PROVIDER" MEANS AN ENTITY THAT DELIVERS HEALTH CARE SERVICES TO CONSUMERS, BUT DOES NOT INCLUDE INDIVIDUAL PHYSICIANS OR PRIMARY CARE PHYSICIANS WHO PARTICIPATE AS A PROVIDER IN THE MEDICAL ASSISTANCE PROGRAM. (g) "MANAGED CARE" MEANS THE DELIVERY BY A SINGLE MANAGED CARE ORGANIZATION, AS DEFINED IN PARAGRAPH (g) OF THIS SUBSECTION (2), OF A PREDEFINED SET OF SERVICES TO CONSUMERS AS DEEMED REASONABLY NECESSARY BY THE PROVIDER OF SERVICES.

(h) "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 HEALTH CARE SERVICES TO CONSUMERS PURSUANT TO THIS SUBPART 2.

(i) "MEDICAL ACCESS" MEANS THE ABILITY TO OBTAIN OR MAKE USE OF MEDICAL SERVICES OFFERED BY MCO'S.

(j) "PILOT PROGRAM" MEANS THE MEDICAL ASSISTANCE CONSUMER CHOICE PROGRAM AUTHORIZED PURSUANT TO THIS SUBPART 2.

(k) "QUALITY OF CARE" MEANS THE STANDARD FOR MEASURING HEALTH STATUS OF AND MEDICAL OUTCOMES FOR INDIVIDUAL CONSUMERS' AND THE TOTAL CONSUMER POPULATIONS SERVED UNDER THE PILOT PROGRAM AUTHORIZED PURSUANT TO THIS SUBPART 2.

(3) **Program development.** (a) IF NECESSARY, ON OR BEFORE JULY 1, 1996, THE STATE DEPARTMENT SHALL SEEK A WAIVER FROM THE FEDERAL GOVERNMENT TO DEVELOP AND IMPLEMENT A MEDICAL ASSISTANCE CONSUMER CHOICE PROGRAM ON A PILOT BASIS.

(b) ON OR BEFORE SEPTEMBER 1, 1996, OR WITHIN SIXTY DAYS AFTER RECEIPT OF APPROVAL OF THE WAIVER, WHICHEVER OCCURS LATER, THE STATE DEPARTMENT SHALL MAKE PREPARATIONS FOR THE IMPLEMENTATION OF THE PILOT PROGRAM. SUCH PREPARATIONS SHALL INCLUDE BUT ARE NOT LIMITED TO STAFF TRAINING, POLICY DEVELOPMENT, AND RULE-MAKING.

(c) NO LATER THAN NOVEMBER 1, 1996, OR WITHIN FOUR MONTHS AFTER RECEIPT OF APPROVAL OF THE WAIVER, WHICHEVER OCCURS LATER, THE STATE DEPARTMENT SHALL SELECT THREE URBAN COUNTIES WITH A POPULATION OF ONE HUNDRED THOUSAND OR MORE AND THREE RURAL COUNTIES WITH A POPULATION OF LESS THAN ONE HUNDRED THOUSAND TO PARTICIPATE IN THE PILOT PROGRAM.

(d) THE PILOT PROGRAM SHALL BE IMPLEMENTED NO LATER THAN JANUARY 1, 1997, OR WITHIN SIX MONTHS AFTER RECEIPT OF APPROVAL OF THE WAIVER, WHICHEVER OCCURS LATER. THE PILOT PROGRAM SHALL BE IN EFFECT FOR A PERIOD OF THREE YEARS OR FOR SO LONG AS SPECIFIED IN THE WAIVER, WHICHEVER IS LONGER.

(4) **Program features.** THE PILOT PROGRAM DESIGNED AND IMPLEMENTED BY THE STATE DEPARTMENT SHALL CONSIST OF THE FOLLOWING PROVISIONS:

(a) MARKETING SYSTEMS THAT ENCOURAGE THE PARTICIPATION OF MCO'S AND CONSUMERS, INCLUDING BUT NOT LIMITED TO THE USE OF HEALTH CARE COVERAGE COOPERATIVES CERTIFIED IN ACCORDANCE WITH ARTICLE 18 OF TITLE 6, C.R.S. THE STATE DEPARTMENT OR A HEALTH CARE COVERAGE COOPERATIVE CERTIFIED BY THE STATE DEPARTMENT TO PARTICIPATE IN THE PILOT PROGRAM SHALL FACILITATE AND PROMOTE LONG-TERM RELATIONSHIPS BETWEEN MCO'S, CONSUMERS, AND, IF APPLICABLE, HEALTH CARE PROVIDERS.

(b) CONSUMERS MADE UP OF ELIGIBLE CONSUMERS FROM A PARTICIPATING COUNTY WHO VOLUNTEER TO PARTICIPATE. ELIGIBLE CONSUMERS WHO CHOOSE NOT TO PARTICIPATE SHALL BE REQUIRED TO PAY A MINIMUM COPAYMENT FOR SERVICES, WHICH COPAYMENT SHALL BE ESTABLISHED BY THE MEDICAL SERVICES BOARD.

(c) TO THE EXTENT AUTHORIZED BY FEDERAL LAW OR WAIVER, INCENTIVES FOR CONSUMERS, INCLUDING BUT NOT LIMITED TO THOSE DESCRIBED IN SUBPARAGRAPH (VIII) OF PARAGRAPH (e) OF THIS SUBSECTION (4);

(d) A CAPITATED CERTIFICATE OF ENROLLMENT PROVIDED TO A CONSUMER OR THE CONSUMER'S REPRESENTATIVE PAYEE FOR THE PURPOSE OF ALLOWING THE CONSUMER TO CHOOSE A MCO TO PROVIDE HEALTH CARE COVERAGE. THE CONSUMER MAY USE A HEALTH CARE COVERAGE COOPERATIVE TO SELECT A MCO. THE CERTIFICATE OF ENROLLMENT MAY BE PRESENTED FOR REIMBURSEMENT TO THE STATE DEPARTMENT OR THE ENTITY

RESPONSIBLE FOR ADMINISTERING PAYMENTS FOR HEALTH CARE COVERAGE PLANS. THE CERTIFICATE OF ENROLLMENT CANNOT BE USED TO PURCHASE DIRECTLY ANY HEALTH CARE SERVICE.

(e) MCO'S SELECTED BY THE STATE DEPARTMENT TO PARTICIPATE IN THE PILOT PROGRAM 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 SUBSECTION (6) OF THIS SECTION THAT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING:

(I) THE MCO WILL NOT INTERFERE WITH APPROPRIATE MEDICAL CARE DECISIONS RENDERED BY THE PROVIDER;

(II) THE MCO WILL MAKE PAYMENTS TO PROVIDERS WITHIN A COMMERCIALLY REASONABLE TIME;

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

(IV) MINIMUM BENEFIT REQUIREMENTS AS ESTABLISHED BY THE MEDICAL SERVICES BOARD, INCLUDING, BUT NOT LIMITED TO, PREVENTIVE CARE, PHARMACEUTICALS, DURABLE MEDICAL EQUIPMENT, CHRONIC CARE, AND ACUTE CARE;

(V) PROVISION OF NECESSARY AND APPROPRIATE SERVICES TO CONSUMERS;

(VI) AN ATTEMPT TO MAKE APPROPRIATE USE OF ANCILLARY HEALTH CARE PROVIDERS SUCH AS PHYSICAL THERAPISTS, OCCUPATIONAL THERAPISTS, SPEECH PATHOLOGISTS, AND NURSE PRACTITIONERS;

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

(VIII) TO THE EXTENT PROVIDED BY LAW OR WAIVER, PROVISION OF CONSUMER INCENTIVES THAT THE MEDICAL SERVICES BOARD SHALL DEVELOP AND IMPLEMENT IN PARTNERSHIP WITH LOCAL GOVERNMENT AND THE PRIVATE SECTOR AND THAT INCLUDE BUT NEED NOT BE LIMITED TO:

(A) INCLUSION OF AT LEAST ONE CONSUMER ON THE MEDICAL SERVICES BOARD;

(B) COPAY OWNERSHIP OF DURABLE MEDICAL EQUIPMENT;

(C) RECOGNITION FOR IMPROVED HEALTH STATUS OUTCOMES;

(D) RECEIPT OF MEDICAL DISPOSABLE SUPPLIES WITHOUT CHARGE.

(E) ALLOWING A CONSUMER, TO THE EXTENT PERMITTED BY LAW, TO RETAIN A PORTION OF THE SAVINGS RESULTING FROM THE CONSUMER'S SELECTION OF A MEDICAL PLAN AT A RATE LOWER THAN THE VALUE OF THE VOUCHER FOR A PURPOSE RELATED TO DELIVERY OF A PUBLIC SERVICE;

(IX) UTILIZATION REQUIREMENTS ESTABLISHED BY THE STATE DEPARTMENT;

(X) A FORM OR PROCESS FOR MEASURING GROUP AND INDIVIDUAL CONSUMER 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 CONSUMER 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.

(XI) FINANCIAL STABILITY OF THE MCO.

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

(XIII) A GRIEVANCE PROCEDURE 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 CONSUMER MAY SEEK AN ADMINISTRATIVE REVIEW OF AN ADVERSE DECISION MADE BY THE MCO.

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

(A) 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;

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

(C) 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;

(D) FOLLOW-UP BASIC HEALTH MAINTENANCE SERVICES FOR WOMEN AND CHILDREN, INCLUDING IMMUNIZATIONS, EPSDT, AND PAP SMEARS FOR WOMEN;

(XX) THAT THE MCO WILL ACCEPT ALL ENROLLEES REGARDLESS OF HEALTH STATUS; EXCEPT THAT THE VALUE OF THE CERTIFICATE OF ENROLLMENT SHALL BE REFLECTIVE OF THIS FACTOR.

(f) MCO INCENTIVES;

(g) ALLOWANCES FOR A CONSUMER TO CHANGE MCO'S FOR GOOD CAUSE AS ESTABLISHED BY THE MEDICAL SERVICES BOARD.

(5) **Data collection.** MCO'S AND HEALTH CARE PROVIDERS PARTICIPATING IN THE PILOT PROGRAM AND THE STATE DEPARTMENT SHALL BE SUBJECT TO THE DATA COLLECTION REQUIREMENTS DESCRIBED IN SECTION 26-4-114.

(6) **Rulemaking.** (a) THE MEDICAL SERVICES BOARD SHALL ADOPT THE RULES CONCERNING THE PILOT PROGRAM. THE RULES SHALL INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING:

(I) CRITERIA FOR THE SELECTION OF PARTICIPATING COUNTIES;

(II) COPAYMENTS TO BE PAID BY ELIGIBLE CONSUMERS WHO CHOOSE NOT TO PARTICIPATE IN THE PILOT PROGRAM;

(III) THE CAPITATED AMOUNT TO BE PAID TO OR ON BEHALF OF CONSUMERS;

(IV) CRITERIA FOR THE SELECTION OF MCO'S THAT MAY PARTICIPATE IN THE PROGRAM, INCLUDING BUT NOT LIMITED TO THE ASSURANCE REQUIREMENTS DESCRIBED IN PARAGRAPH (e) OF SUBSECTION (4) OF THIS SECTION;

(V) BONDING REQUIREMENTS FOR MCO'S;

(VI) ADDITIONAL REQUIREMENTS FOR HEALTH CARE COVERAGE COOPERATIVES, WHICH REQUIREMENTS SHALL RELATE TO SERVING THE MEDICAL ASSISTANCE POPULATION PARTICIPATING IN THE PILOT PROGRAM;

(VII) THE FORM AND AMOUNT OF MCO AND CONSUMER INCENTIVES FOR PARTICIPATING IN THE PILOT PROGRAM;

(VIII) A DEFINITION OF "GOOD CAUSE" AS THE BASIS FOR ALLOWING CONSUMERS TO CHANGE MCO'S;

(IX) A PROCESS FOR RECOVERING THE CAPITATED PAYMENT MADE TO OR ON BEHALF OF A CONSUMER WHO CHANGES MCO'S FOR GOOD CAUSE OR FOR PAYING FOR SERVICES RENDERED BY THE NEW MCO;

(X) A PROCESS BY WHICH THE STATE DEPARTMENT OR AN AGENCY ACTING FOR THE STATE DEPARTMENT PERFORMS SYSTEMATIC EVALUATIONS OF THE MCO'S AND HEALTH CARE PROVIDES. THE PURPOSE OF THE EVALUATION IS TO DETERMINE WHETHER AN MCO OR PROVIDER HAS THE CAPACITY TO SERVE SPECIAL NEEDS OF THE PARTICIPANTS IN THE PILOT PROGRAM. AGENCIES ACTING FOR THE STATE DEPARTMENT MAY INCLUDE, BUT ARE NOT LIMITED TO, THE APPROPRIATE HEALTH CARE COOPERATIVE OR THE PEER REVIEW ORGANIZATION FOR THE STATE.

(XI) A PROCEDURE UNDER WHICH INDIVIDUAL PARTICIPANTS MAY DISENROLL FROM AN INDIVIDUAL HEALTH CARE PLAN AND FROM THE PILOT PROGRAM AND CONTINUE ELIGIBILITY UNDER THE MEDICAL ASSISTANCE PROGRAM, AND A PROCEDURE FOR TRANSFERRING CONSUMERS FROM ONE HEALTH COVERAGE PLAN TO ANOTHER IN THE EVENT A HEALTH CARE COVERAGE PLAN ADMINISTRATOR IS ELIMINATED FROM THE PROGRAM; EXCEPT THAT A CHANGE OF MCO PURSUANT TO THIS SECTION SHALL NOT LIMIT A CONSUMER FROM PURSUING ANY OTHER REMEDY PROVIDED BY LAW;

(XII) APPROPRIATE EDUCATIONAL AND MARKETING TOOLS TO BE IMPLEMENTED BY HEALTH COVERAGE COOPERATIVES AND MCO'S;

(XIII) ANY OTHER RULES PURSUANT TO ARTICLE 4 OF TITLE 24, C.R.S., NECESSARY TO IMPLEMENT THIS SECTION.

(XIV) MCO SANCTIONS FOR FAILING TO COMPLY WITH UTILIZATION, DATA COLLECTION, AND REPORTING REQUIREMENTS OR FOR CONSUMER DISSATISFACTION.

(7) **Implementation contingent upon receipt of federal waiver - statewide implementation of this section - repeal.** (a) THE IMPLEMENTATION OF THIS SECTION IS CONDITIONED, TO THE EXTENT APPLICABLE, ON THE ISSUANCE OF NECESSARY WAIVERS BY THE FEDERAL GOVERNMENT, AVAILABLE APPROPRIATIONS, AND SUFFICIENT SITES FOR THE PILOT PROGRAM. THE PROVISIONS OF THIS SECTION SHALL BE IMPLEMENTED TO THE EXTENT AUTHORIZED BY FEDERAL WAIVER, IF SO REQUIRED BY FEDERAL LAW.

(b) THE STATE DEPARTMENT SHALL SUBMIT A REPORT TO THE GENERAL ASSEMBLY AS TO THE PROVISIONS THAT HAVE BEEN APPROVED BY FEDERAL WAIVER AND SHALL RECOMMEND LEGISLATION THAT CONFORMS WITH THE WAIVER PROVISIONS NO LATER THAN THE NEXT REGULAR LEGISLATIVE SESSION FOLLOWING THE ISSUANCE OF THE WAIVER.

(c) THE PROVISIONS OF THIS SECTION APPROVED BY THE FEDERAL GOVERNMENT AND AUTHORIZED BY FEDERAL WAIVER SHALL REMAIN IN EFFECT ONLY FOR AS LONG AS SPECIFIED IN THE FEDERAL WAIVER OR UNTIL JULY 1, 1999. THE STATE DEPARTMENT SHALL PROVIDE WRITTEN NOTICE TO THE

REVISOR OF STATUTES OF THE DATE SPECIFIED IN THE WAIVER, AND SUBPART 1 OF THIS PART 1 AND THIS SUBPART 2 SHALL BE REPEALED, EFFECTIVE JULY 1 OF THE YEAR SPECIFIED IN THE WAIVER.

(d) THIS SECTION IS REPEALED, EFFECTIVE JULY 1, 1999, UNLESS REPEALED PRIOR TO SAID DATE IN ACCORDANCE WITH SUBSECTION (3) OF THIS SECTION. ON AND AFTER THAT DATE, THE STATE DEPARTMENT SHALL IMPLEMENT THE PILOT PROGRAM ON A STATEWIDE BASIS IN ACCORDANCE WITH SECTION 26-4-113.

(8) **Applicability of certain provisions of act.** THE PROVISIONS OF SECTION 26-4-404 SHALL NOT APPLY TO THIS SECTION TO THE EXTENT THAT SUCH PROVISIONS CONFLICT WITH THE PROVISIONS OF THIS SECTION.

26-4-118 to 26-4-125. (Reserved)

SECTION 2. 6-18-206 (1) (e), the introductory portion to (1) (g), and 6-18-206 (2) (c) and (2) (i), Colorado Revised Statutes, 1992 Repl. Vol., as amended, are amended to read:

6-18-206. Powers, duties, and responsibilities of cooperatives. (1) Each cooperative organized pursuant to this part 2 shall:

(e) Offer to all members and their eligible employees the standard and basic health benefit plans promulgated pursuant to section 10-8-606, C.R.S.; EXCEPT THAT, WITH RESPECT TO CONSUMERS DEFINED IN SECTION 26-4-117 (2), C.R.S., THE COOPERATIVE SHALL OFFER BASIC HEALTH BENEFIT PLANS REQUIRED IN RULES ADOPTED BY THE MEDICAL SERVICES BOARD PURSUANT TO SECTION 26-4-117 (6), C.R.S.;

(g) Contract only for insurance functions listed in section 10-3-903, C.R.S., OR, WITH RESPECT TO CONSUMERS DEFINED IN SECTION 26-4-117 (2), C.R.S., INSURANCE FUNCTIONS INCLUDED IN RULES ADOPTED BY THE MEDICAL SERVICES BOARD PURSUANT TO SECTION 26-4-117 (6), C.R.S., with entities authorized to do business in this state by the division of insurance pursuant to title 10, C.R.S., which have:

(2) Each cooperative organized pursuant to this part 2 may:

(c) Offer any and all health benefit packages permitted under law in addition to the standard and basic health benefit plans promulgated pursuant to section 10-8-606, C.R.S.; EXCEPT THAT, WITH RESPECT TO CONSUMERS DEFINED IN SECTION 26-4-117 (2), C.R.S., THE COOPERATIVE SHALL OFFER BASIC HEALTH BENEFIT PLANS REQUIRED IN RULES ADOPTED BY THE MEDICAL SERVICES BOARD PURSUANT TO SECTION 26-4-117 (6), C.R.S.;

(i) Exclude any carrier, provider network, or provider or freeze enrollment in any carrier, provider network, or provider for failure to achieve established quality, access, or information reporting standards of the cooperative; EXCEPT THAT, WITH RESPECT TO MANAGED CARE ORGANIZATIONS THAT PARTICIPATE IN THE MEDICAL ASSISTANCE CONSUMER CHOICE PROGRAM SET FORTH IN SUBPART 2 OF PART 1 OF ARTICLE 4 OF TITLE 26, C.R.S., EXCLUDE ANY MANAGED CARE ORGANIZATION FOR FAILURE TO ACHIEVE ESTABLISHED QUALITY, ACCESS, OR INFORMATION REPORTING STANDARDS ADOPTED BY THE MEDICAL SERVICES BOARD PURSUANT TO SECTION 26-4-117 (6), C.R.S.;

SECTION 3. 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, and 6-18-207, 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 4. 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 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.