Second Regular Session
Seventy-fourth General Assembly
STATE OF COLORADO

PREAMENDED

This Unofficial Version Includes Committee Amendments Not Yet Adopted on Second Reading

LLS NO. 24-0046.01 Shelby Ross x4510 **SENATE BILL 24-176**

SENATE SPONSORSHIP

Ginal and Hinrichsen,

HOUSE SPONSORSHIP

Epps and McLachlan,

Senate Committees
State, Veterans, & Military Affairs

House Committees

A BILL FOR AN ACT

CONCERNING UPDATING THE TERMINOLOGY THAT REFERS TO AN INDIVIDUAL WHO IS ENROLLED IN THE STATE MEDICAL ASSISTANCE PROGRAM.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov/.)

Statutory Revision Committee. Current law refers to a "member", "client", "consumer", and "recipient" interchangeably when referring to an individual who is enrolled in the state medical assistance program (medicaid). The bill updates the terminology to refer only to medicaid "members".

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

SECTION 1. In Colorado Revised Statutes, 25.5-1-103, **amend** (6) as follows:

25.5-1-103. Definitions. As used in this title 25.5, unless the context otherwise requires:

(6) ~~"Recipient"~~ "MEMBER" means any person who has been determined eligible to receive benefits or services under this ~~title~~ TITLE 25.5.

SECTION 2. In Colorado Revised Statutes, 25.5-1-107, **amend** (1) as follows:

25.5-1-107. Final agency action - administrative law judge - authority of executive director. (1) The executive director may appoint one or more ~~persons~~ INDIVIDUALS to serve as administrative law judges for the state department pursuant to section 24-4-105 and pursuant to part 10 of article 30 of title 24 subject to appropriations made to the department of personnel. Except as provided in subsection (2) of this section, hearings conducted by the administrative law judge are considered initial decisions of the state department and ~~shall be reviewed by~~ the executive director or ~~a~~ THE EXECUTIVE DIRECTOR'S designee ~~of the executive director. In the event~~ SHALL REVIEW THE INITIAL DECISIONS. IF exceptions to the initial decision are filed pursuant to section 24-4-105 (14)(a)(I), the review must be CONDUCTED in accordance with section 24-4-105 (15). In the absence of any exception filed pursuant to section 24-4-105 (14)(a)(I), the executive director OR THE EXECUTIVE DIRECTOR'S DESIGNEE shall review the initial decision in accordance with a procedure adopted by the state board. The procedure must be consistent with federal

mandates concerning the single state agency requirement. Review by the executive director OR THE EXECUTIVE DIRECTOR'S DESIGNEE in accordance with section 24-4-105 (15) or the procedure adopted by the state board pursuant to this section constitutes final agency action. The administrative law judge may conduct hearings on appeals from decisions of county departments of human or social services brought by ~~recipients~~ MEMBERS of and applicants for medical assistance and welfare that are required by law in order for the state to qualify for federal funds, and the administrative law judge may conduct other hearings for the state department. Notice of any ~~such~~ hearing must be served at least ten days prior to ~~such~~ THE hearing.

SECTION 3. In Colorado Revised Statutes, 25.5-1-115, **amend** (3) as follows:

25.5-1-115. Locating violators - recoveries. (3) Whenever a county department, a county board, a district attorney, or the state department on behalf of the county recovers any amount of medical assistance payments that were obtained through unintentional ~~client~~ MEMBER error, the federal government ~~shall be~~ IS entitled to a share proportionate to the amount of federal funds paid, unless a different amount is provided for by federal law; the state ~~shall be~~ IS entitled to a share proportionate to seventy-five percent of the amount of state funds paid; AND the county ~~shall be~~ IS entitled to a share proportionate to the amount of county funds paid, if any, and, in addition, a share proportionate to twenty-five percent of the amount of state funds paid.

SECTION 4. In Colorado Revised Statutes, 25.5-1-115.5, **amend** (1) introductory portion, (1)(a), (1)(b), and (1)(e) as follows:

25.5-1-115.5. Medical assistance fraud - report.

(1) Notwithstanding ~~the provisions of~~ section 24-1-136 (11)(a)(I), on or before November 1, 2017, and ~~on or before~~ EACH November 1 ~~each year~~ thereafter, the state department shall submit a written report to the joint budget committee; TO the HOUSE OF REPRESENTATIVES judiciary committee and the HOUSE OF REPRESENTATIVES public AND BEHAVIORAL health ~~care~~ and human services committee, ~~of the house of representatives,~~ or their successor committees; and to the SENATE judiciary committee and the SENATE health and human services committee, ~~of the senate,~~ or their successor committees, concerning fraud in the medicaid program. The state department shall compile a single, comprehensive report that includes the information described in this subsection (1), as well as information that the attorney general provides to the state department pursuant to section 25.5-4-303.3. The state department shall report to the general assembly concerning the fraudulent receipt of medicaid benefits, including, at a minimum:

(a) Investigations of ~~client~~ MEMBER fraud during the year;

(b) Termination of ~~client~~ MEMBER medicaid benefits due to fraud;

(e) Trends in methods used to commit ~~client~~ MEMBER fraud, excluding law enforcement-sensitive information; and

SECTION 5. In Colorado Revised Statutes, 25.5-1-116, **amend** (1), (2)(c)(I), (2)(c)(III), (2)(d), and (3) as follows:

25.5-1-116. Records confidential - authorization to obtain records of assets - release of location information to law enforcement agencies - outstanding felony arrest warrants. (1) The state department may establish reasonable rules to provide safeguards restricting the use or disclosure of information concerning applicants, ~~recipients~~ MEMBERS, and former and potential ~~recipients~~ MEMBERS of

medical assistance ~~to~~ FOR purposes directly connected with the administration of ~~such~~ medical assistance and related state department activities, ~~and covering~~ INCLUDING the custody, use, and preservation of the STATE'S AND THE COUNTY DEPARTMENTS' records, papers, files, and communications. ~~of the state and county departments.~~ Whenever, ~~under provisions of~~ AS REQUIRED BY law, THE names and addresses of applicants for, ~~recipients~~ MEMBERS of, or former and potential ~~recipients~~ MEMBERS of medical assistance are furnished to or held by another agency or department of government, ~~such~~ THE agency or department shall ~~be required to~~ prevent the publication of lists ~~thereof~~ OF THE NAMES AND ADDRESSES and ~~their uses~~ PREVENT USING THE NAMES AND ADDRESSES for purposes not directly connected with the administration of ~~such~~ medical assistance.

(2) (c) (I) In order to determine if applicants for or ~~recipients~~ MEMBERS of medical assistance have assets within eligibility limits, the state department may provide a list of information identifying ~~these~~ THE applicants or ~~recipients~~ MEMBERS to any financial institution, as defined in section 15-15-201 (4), ~~C.R.S.,~~ or to any insurance company. ~~This~~ THE information PROVIDED may include identification numbers or social security numbers. The state department may require ~~any such~~ A financial institution or insurance company to provide a written statement disclosing any assets held on behalf of individuals adequately identified on the list provided. Before a termination notice is sent to the ~~recipient~~ MEMBER, the county department or the medical assistance site, in verifying the accuracy of the information obtained as a result of the match, shall contact the ~~recipient~~ MEMBER and inform the ~~recipient~~ MEMBER of the apparent results of the computer match and give the ~~recipient~~ MEMBER the

opportunity to explain or correct any erroneous information secured by the match. The requirement to run a computerized match ~~shall apply~~ APPLIES only to information that is entered in the financial institution's or insurance company's data processing system on the date the match is run and ~~shall not be deemed to~~ DOES NOT require any ~~such~~ FINANCIAL institution or INSURANCE company to change its data or make new entries for the purpose of comparing identifying information. The STATE DEPARTMENT SHALL PAY FOR THE cost of providing ~~such~~ A computerized match. ~~shall be borne by the state department.~~

(III) The state department may expend funds appropriated pursuant to ~~subparagraph (II) of this paragraph (c)~~ SUBSECTION (2)(c)(II) OF THIS SECTION in an amount not to exceed the amount of annualized general fund savings that result from the termination of ~~recipients~~ MEMBERS from medical assistance specifically due to disclosure of assets pursuant to this subsection (2).

(d) ~~No~~ AN applicant ~~shall~~ MUST NOT be denied ~~nor~~ OR any ~~recipient~~ MEMBER MUST NOT BE discontinued due to the disclosure of ~~their~~ assets unless and until the county department or medical assistance site has assured that ~~such~~ THE assets taken together with other assets exceed the limit for eligibility of countable assets. Any information concerning assets found may be used to determine if ~~such~~ THE applicant's or ~~recipient's~~ MEMBER'S eligibility for other medical assistance is affected.

(3) The applicant for or ~~recipient~~ MEMBER of medical assistance, or ~~his or her~~ THE APPLICANT'S OR MEMBER'S representative, ~~shall have~~ HAS an opportunity to examine all applications and pertinent records concerning ~~said~~ THE applicant or ~~recipient which~~ MEMBER THAT constitute a basis for denial, modification, or termination of ~~such~~ medical assistance

or to examine ~~such~~ THE records in case of a fair hearing.

SECTION 6. In Colorado Revised Statutes, 25.5-1-124, **amend** (2) as follows:

25.5-1-124. Early intervention payment system - participation by state department - rules - definitions. (2) The state department shall ensure that the early intervention services and payments for ~~recipients~~ MEMBERS of medical assistance pursuant to this title 25.5 are integrated into the coordinated early intervention payment system developed pursuant to part 4 of article 3 of title 26.5. To the extent necessary to achieve the coordinated payment system and coverage of those early intervention services pursuant to this title 25.5, the state department shall amend the state plan for medical assistance or seek the necessary federal authorization, promulgate rules, and modify the billing system for medical assistance to facilitate the coordinated payment system.

SECTION 7. In Colorado Revised Statutes, **amend** 25.5-1-127 as follows:

25.5-1-127. Third-party benefit denials information. The state department shall provide information to ~~recipients of benefits~~ MEMBERS WHO RECEIVE BENEFITS under this ~~title~~ TITLE 25.5 concerning ~~their~~ THE MEMBERS' right to appeal a denial of benefits by a third party and shall post information on the state department's website concerning ~~recipients'~~ MEMBERS' abilities to appeal a third party's denial of benefits, including but not limited to providing a link to information on the insurance commissioner's website regarding ~~such~~ appeals.

SECTION 8. In Colorado Revised Statutes, 25.5-1-128, **amend** (2) as follows:

25.5-1-128. Provider payments - compliance with state fiscal

requirements - definitions - rules. (2) As used in this section, unless the context otherwise ~~provides~~ REQUIRES, "provider" means a health-care provider, a mental health-care provider, a pharmacist, a home health agency, a general provider as defined in section 25.5-3-103 (3), A school district as defined in section 25.5-5-318 (1)(a), or any other entity that provides health care, health-care coordination, outreach, enrollment, or administrative support services to ~~recipients~~ MEMBERS through fee-for-service, ~~the primary care physician program,~~ a managed care entity, a behavioral health organization, a medical home, or any system of care that coordinates health care or services as defined and authorized through rules promulgated by the state board or by the executive director.

SECTION 9. In Colorado Revised Statutes, **amend** 25.5-1-130 as follows:

25.5-1-130. Improving access to behavioral health services for individuals at risk of entering the criminal or juvenile justice system - duties of the state department. (1) On or before March 1, 2020, the state department shall develop measurable outcomes to monitor efforts to prevent medicaid ~~recipients~~ MEMBERS from becoming involved in the criminal or juvenile justice system.

(2) On or before July 1, 2021, the state department shall work collaboratively with managed care entities to create incentives for behavioral health providers to accept medicaid ~~recipients~~ MEMBERS with severe behavioral health disorders. The incentives may include, but need not be limited to, higher reimbursement rates, quality payments to managed care entities for adequate networks, establishing performance measures and performance improvement plans related to network expansion, transportation solutions to incentivize medicaid ~~recipients~~

MEMBERS to attend health-care appointments, and incentivizing providers to conduct outreach to medicaid ~~recipients~~ MEMBERS to ensure that they are engaged in needed behavioral health services, including technical assistance with billing procedures. The state department may seek any federal authorization necessary to create the incentives described in this subsection (2).

SECTION 10. In Colorado Revised Statutes, 25.5-1-133, **amend** (1) as follows:

25.5-1-133. Access to behavioral health services for individuals under twenty-one years of age - rules - report - repeal. (1) On or before July 1, 2024, the state department shall provide ~~recipients~~ MEMBERS under twenty-one years of age with access to limited services without requiring a diagnosis. The limited services must be provided as part of the statewide managed care system pursuant to part 4 of article 5 of this title 25.5 and the school health services detailed in section 25.5-5-318.

SECTION 11. In Colorado Revised Statutes, 25.5-1-205, **amend** (2) as follows:

25.5-1-205. Providing for the efficient provision of health care through state-supervised cooperative action - rules. (2) The executive director shall facilitate departmental oversight of collaboration among providers, medicaid ~~clients~~ MEMBERS and advocates, and ~~payors~~ PAYERS that is designed to improve health outcomes and patient satisfaction and support the financial sustainability of the medicaid program.

SECTION 12. In Colorado Revised Statutes, 25.5-1-303, **amend** (3)(b), (3)(c), (3)(d), (3)(e), and (3)(f) as follows:

25.5-1-303. Powers and duties of the board - scope of authority

- rules. (3) The board shall adopt rules in connection with the programs set forth in subsection (1) of this section governing the following:

(b) The establishment of eligibility requirements for ~~persons~~ MEMBERS receiving services from the state department;

(c) The establishment of the type of benefits that ~~a recipient of services may obtain~~ ARE AVAILABLE TO AN APPLICANT if eligibility requirements are met, subject to the authorization, requirements, and availability of ~~such~~ THE benefits;

(d) The requirements, obligations, and rights of ~~clients and recipients~~ MEMBERS AND APPLICANTS;

(e) The establishment of a procedure to resolve disputes that may arise between ~~clients~~ MEMBERS and the state department or ~~clients~~ MEMBERS and providers;

(f) The requirements, obligations, and rights of providers, including policies and procedures related to provider payments that may affect ~~client~~ MEMBER benefits;

SECTION 13. In Colorado Revised Statutes, 25.5-1-801, **amend** (2) and (5) as follows:

25.5-1-801. Definitions. As used in this section, unless the context otherwise requires:

(2) "Nonmedical transportation" means transportation to enable passengers who are ~~recipients of~~ medicaid MEMBERS to gain access to waiver and other community services, activities, and resources.

(5) "Transportation services" means nonemergency medical transportation or nonmedical transportation services provided to medicaid ~~recipients~~ MEMBERS.

SECTION 14. In Colorado Revised Statutes, 25.5-1-802, **amend**

(1) introductory portion as follows:

25.5-1-802. Medicaid transportation services - safety and oversight - rules. (1) The state department shall collaborate with stakeholders, including, but not limited to, disability and ~~member~~ CONSUMER advocates, PACE providers operating pursuant to section 25.5-5-412, transportation brokers, and transportation providers, to establish rules and processes for the safety and oversight of nonmedical transportation services and nonemergency medical transportation services provided to medicaid ~~recipients~~ MEMBERS pursuant to articles 4 to 6 of this title 25.5. The rules and processes must:

SECTION 15. In Colorado Revised Statutes, 25.5-2-101, **amend** (2) as follows:

25.5-2-101. Old age pension health and medical care fund - supplemental old age pension health and medical care fund - cash system of accounting - legislative declaration - rules. (2) Any money remaining in the state old age pension fund after full payment of basic minimum awards to qualified old age pension ~~recipients~~ MEMBERS, and after establishment and maintenance of the old age pension stabilization fund in the amount of five million dollars, ~~shall~~ MUST be transferred to a fund to be known as the old age pension health and medical care fund, which is ~~hereby~~ created. The state board shall establish and promulgate rules for administration of a program to provide health and medical care to persons who qualify to receive old age pensions and who are not patients in an institution for tuberculosis or behavioral or mental health disorders. The costs of such program, not to exceed ten million dollars in any fiscal year, are defrayed from the health and medical care fund, but all money available, accrued or accruing, received or receivable, in ~~said~~

THE health and medical care fund in excess of ten million dollars in any fiscal year is transferred to the general fund of the state to be used pursuant to law. Money in the old age pension health and medical care fund is subject to annual appropriation by the general assembly.

SECTION 16. In Colorado Revised Statutes, 25.5-2.5-204, **amend** (3)(a) as follows:

25.5-2.5-204. Eligible prescription drugs - eligible Canadian suppliers - eligible importers - distribution requirements. (3) The following entities are eligible importers and may obtain imported prescription drugs:

(a) A pharmacist or wholesaler employed by or under contract with a medicaid pharmacy, for dispensing to the pharmacy's medicaid ~~recipients~~ MEMBERS;

SECTION 17. In Colorado Revised Statutes, 25.5-3-104, **amend** (2) as follows:

25.5-3-104. Program for the medically indigent established - eligibility - rules. (2) A ~~client's~~ PERSON'S eligibility to receive discounted services under the program for the medically indigent ~~shall be~~ IS determined by rule of the state board based on a specified percentage of the federal poverty line, adjusted for family size, which percentage ~~shall~~ MUST not be less than two hundred fifty percent.

SECTION 18. In Colorado Revised Statutes, 25.5-4-103, **amend** (11), (13), (22), (26), and (28); **repeal** (21); and **add** (13.2) as follows:

25.5-4-103. Definitions. As used in this article 4 and articles 5 and 6 of this title 25.5, unless the context otherwise requires:

(11) "Liable" or "liability" means the legal liability of a third party, either by reason of judgment, settlement, compromise, or contract,

as the result of negligent acts or other wrongful acts or otherwise for all or any part of the medical cost of an injury, a disease, or the disability of an applicant for or ~~recipient~~ MEMBER of medical assistance.

(13) "Medical assistance" means payment on behalf of ~~recipients~~ MEMBERS eligible for and enrolled in the STATE MEDICAL ASSISTANCE program established ~~in articles 4, 5, and 6~~ PURSUANT TO THIS ARTICLE 4 AND ARTICLES 5 AND 6 of this ~~title~~ TITLE 25.5, which is funded through Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396u-1, to PROVIDERS enrolled ~~providers under~~ IN the state medical assistance program ~~of~~ WHO RENDER OR PROVIDE medical care, services, goods, and devices ~~rendered or provided to recipients under this article~~ TO MEMBERS PURSUANT TO THIS ARTICLE 4 and articles 5 and 6 of this ~~title~~ TITLE 25.5, and other related payments, pursuant to this ~~article~~ ARTICLE 4 and articles 5 and 6 of this ~~title~~ TITLE 25.5 and the rules of the state department.

(13.2) "MEMBER" MEANS A PERSON WHO HAS BEEN DETERMINED ELIGIBLE TO RECEIVE BENEFITS UNDER THIS ARTICLE 4 AND ARTICLES 5 AND 6 OF THIS TITLE 25.5.

(21) ~~"Recipient" means any person who has been determined eligible to receive benefits under this article and articles 5 and 6 of this title, whose need for medical care has been professionally established, and for whose care less than full payment is available through the legal obligation of a contractor, public or private, to pay for or provide such care.~~

(22) "Recovery" or "amount recovered" means the amount payable to the applicant or ~~recipient~~ MEMBER or ~~his~~ THE APPLICANT'S OR MEMBER'S heirs, assigns, or legal representatives as the result of any liability of a third party.

(26) "Third party" means an individual, institution, corporation, or public or private agency ~~which~~ THAT is or may be liable to pay all or any part of the medical cost of an injury, a disease, or the disability of an applicant for or ~~recipient~~ MEMBER of medical assistance.

(28) "Transitional medicaid" means the medical assistance provided to ~~recipients~~ MEMBERS eligible pursuant to section 25.5-5-101 (1)(b).

SECTION 19. In Colorado Revised Statutes, **amend** 25.5-4-104 as follows:

25.5-4-104. State medical assistance program - single state agency. (1) The state department, by rules, 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~~ THE MEDICAL ASSISTANCE program in accordance with Title XIX OF THE FEDERAL "SOCIAL SECURITY ACT" and this ~~article~~ ARTICLE 4 and articles 5 and 6 of this ~~title. Such~~ TITLE 25.5. THE program ~~shall not be~~ IS NOT required to furnish ~~recipients~~ TO MEMBERS under sixty-five years of age the benefits that are provided to ~~recipients~~ MEMBERS sixty-five years of age and over under Title XVIII of the ~~social security act~~ FEDERAL "SOCIAL SECURITY ACT", but ~~said~~ THE MEDICAL ASSISTANCE program ~~shall~~ MUST otherwise be uniform to the extent required by Title XIX of the ~~social security act~~ FEDERAL "SOCIAL SECURITY ACT".

(2) The state department may review any decision of a county department and may consider any application upon which a decision has not been made by the county department within a reasonable time to determine the propriety of the action or failure to take timely action on an

application for medical assistance. The state department shall ~~make such~~ CONDUCT ANY additional investigation ~~as it~~ the STATE DEPARTMENT deems necessary. ~~and shall,~~ After giving the county department an opportunity to rebut ~~any~~ THE STATE DEPARTMENT'S findings or conclusions ~~of the state department~~ that the action or delay in taking action was a violation of or contrary to state department rules, THE STATE DEPARTMENT SHALL make ~~such~~ A decision ~~as to the granting of~~ WHETHER TO GRANT medical benefits and the amount ~~thereof as in its opinion is justifiable~~ OF MEDICAL BENEFITS pursuant to ~~the provisions of this article~~ THIS ARTICLE 4 and articles 5 and 6 of this ~~title~~ TITLE 25.5 and the rules of the state department. Applicants or ~~recipients~~ MEMBERS affected by ~~such~~ THE STATE DEPARTMENT'S decisions, ~~of the state department,~~ upon request, ~~shall~~ MUST be given reasonable notice and opportunity for a fair hearing by the state department.

SECTION 20. In Colorado Revised Statutes, **amend** 25.5-4-107 as follows:

25.5-4-107. Retaliation definition. (1) For purposes of any rules promulgated by the state department or state board and any action taken by the state department against any person, "retaliation" means taking any of the following actions against a ~~recipient~~ MEMBER or someone acting on behalf of a ~~recipient~~ MEMBER after the ~~recipient~~ MEMBER or someone acting on behalf of the ~~recipient~~ MEMBER files a complaint concerning services provided or not provided to the ~~recipient~~ MEMBER:

(a) Indicating to a ~~recipient~~ MEMBER that the ~~recipient~~ MEMBER cannot have an advocate, family member, or other authorized representative assist the ~~recipient~~ MEMBER; or

(b) (I) An adverse action that negatively affects a ~~recipient's~~

MEMBER'S level of eligibility for or receipt of services received at the time of the complaint without verification of a change in the ~~recipient's~~ MEMBER'S income, resources, or health-care needs that justifies the adverse action.

(II) ~~No~~ AN adverse action ~~shall~~ MUST NOT be taken against a ~~recipient~~ MEMBER after a complaint has been filed until the ~~recipient~~ MEMBER is notified of the proposed action, informed of the reason for the proposed action, and provided an opportunity to appeal the proposed action.

(2) "Retaliation" ~~shall~~ DOES not include instances ~~where~~ WHEN a ~~recipient~~ MEMBER is not eligible for a service or program or ~~where~~ WHEN a provider documents a problem with a ~~recipient~~ MEMBER and shares the documentation with the ~~recipient~~ MEMBER or a third party prior to the ~~recipient~~ MEMBER filing a complaint.

SECTION 21. In Colorado Revised Statutes, 25.5-4-203, **amend** (2) as follows:

25.5-4-203. Advisory council established. (2) ADVISORY COUNCIL members serve at the pleasure of the governor and receive no compensation but are entitled to reimbursement for ~~their~~ actual and necessary expenses. The advisory council shall advise the state department on the provision of health and medical care services to ~~recipients~~ MEMBERS OF MEDICAL ASSISTANCE.

SECTION 22. In Colorado Revised Statutes, 25.5-4-205, **amend** (3)(a) introductory portion, (3)(b)(I)(B), (3)(b)(I.5)(A), (3)(e)(I), (3)(e)(II)(A), and (3)(e)(II)(B) as follows:

25.5-4-205. Application - verification of eligibility - demonstration project - rules - repeal. (3) (a) The state department

shall promulgate rules to simplify the processing of applications in order that medical benefits are furnished to ~~recipients~~ MEMBERS as soon as possible, including rules that:

(b) (I) The state department shall promulgate rules that:

(B) Require the state department at least annually to verify a ~~recipient's~~ MEMBER'S income eligibility at reenrollment through federally approved electronic data sources and, if the ~~recipient~~ MEMBER meets all eligibility requirements, permit the ~~recipient~~ MEMBER to remain enrolled in the MEDICAL ASSISTANCE program. The rules ~~shall~~ MUST only require an individual to provide documentation verifying income if electronic data is not available or the information obtained from electronic data sources is not reasonably compatible with information provided by or on behalf of an applicant.

(I.5) (A) If the state department determines that a ~~recipient~~ MEMBER was not eligible for medical benefits solely based upon the ~~recipient's~~ MEMBER'S income after the ~~recipient~~ MEMBER had been determined to be eligible based upon electronic data obtained through a federally approved electronic data source, the state department shall not pursue recovery from a county department for the cost of medical services provided to the ~~recipient~~ MEMBER, and the county department is not responsible for any federal error rate sanctions resulting from ~~such~~ THE determination.

(e) (I) In collaboration with and to augment the state department's efforts to simplify eligibility determinations for benefits under the state medical assistance program and the children's basic health plan, the state department shall establish a process so that a ~~recipient, enrollee,~~ MEMBER, or the parent or guardian of a ~~recipient or enrollee~~ MEMBER may apply for

reenrollment either over the telephone or through the internet.

(II) (A) Subject to receipt of federal authorization and spending authority, the state department may implement a pilot program that allows a limited number of ~~recipients or enrollees~~ MEMBERS to apply for reenrollment either over the telephone or through the internet during a transition to a process that will serve ~~recipients and enrollees~~ MEMBERS statewide. The pilot program ~~shall not serve as~~ IS NOT a replacement for a statewide process.

(B) Notwithstanding any other provision in this ~~paragraph (c)~~ SUBSECTION (3)(e), the state department shall not implement this ~~paragraph (c)~~ SUBSECTION (3)(e) until ~~it~~ THE STATE DEPARTMENT can verify the eligibility of a ~~recipient or enrollee~~ MEMBER over the telephone or through the internet as authorized by rules of the state department and federal law.

SECTION 23. In Colorado Revised Statutes, 25.5-4-205.5, **amend** (2) as follows:

25.5-4-205.5. Confined persons - suspension of benefits. (2) Notwithstanding any other provision of law, a person who, immediately prior to becoming a confined person, was a ~~recipient~~ MEMBER of medical assistance pursuant to this article 4 or article 5 or 6 of this title 25.5, remains eligible for medical assistance while a confined person; except that medical assistance may not be furnished pursuant to this article 4 or article 5 or 6 of this title 25.5 while the person is a confined person unless federal financial participation is available for the cost of the assistance, including, but not limited to, juveniles held in a facility operated by or under contract to the division of youth services established pursuant to section 19-2.5-1501 or the department of human

services. Once a person is no longer a confined person, the person ~~continues to be~~ IS eligible for receipt of medical ~~benefits~~ ASSISTANCE pursuant to this article 4 or article 5 or 6 of this title 25.5 until the person is determined to be ineligible for the receipt of the assistance. To the extent permitted by federal law, the time during which a person is a confined person is not included in any calculation of when the person must ~~recertify his or her~~ RENEW THE PERSON'S eligibility for medical assistance pursuant to this article 4 or article 5 or 6 of this title 25.5.

SECTION 24. In Colorado Revised Statutes, 25.5-4-207, **amend** (1)(a), (1)(b), (1)(c), and (1)(d.5)(I) as follows:

25.5-4-207. Appeals - rules - applicability. (1) (a) (I) If an application for medical assistance is not acted upon within a reasonable time after filing ~~of the same~~ THE APPLICATION, or if an application is denied in whole or in part, or if medical assistance benefits are suspended, terminated, or modified, the applicant or ~~recipient, as the case may be,~~ MEMBER may appeal to the state department in the manner and form prescribed by the rules of the state department. Except as permitted under federal law, state department rules must provide for at least a ten-day advance notice before the effective date of any suspension, termination, or modification of medical assistance. The county DEPARTMENT or designated service agency shall notify the applicant or ~~recipient~~ MEMBER in writing of the basis for the ~~county's~~ decision or action and shall inform the applicant or ~~recipient~~ MEMBER of the right to a county DEPARTMENT or service agency conference under the dispute resolution process described in ~~paragraph (b) of this subsection (1)~~ SUBSECTION (1)(b) OF THIS SECTION and of the right to a state-level appeal and the process for appeal.

(II) The applicant or ~~recipient~~ MEMBER has sixty days after the date of the notice to file an appeal. If the ~~recipient~~ MEMBER files an appeal prior to the effective date of the intended action, existing medical assistance benefits must automatically continue unchanged until the appeal process is completed, unless the ~~recipient~~ MEMBER requests in writing that medical assistance benefits not continue during the appeal process; except that, to the extent authorized by federal law, ~~the~~ state department rules may permit existing medical assistance benefits to continue until the appeal process is completed even if the ~~recipient's~~ MEMBER'S appeal is filed after the effective date of the intended action. The state department shall promulgate rules consistent with federal law that prescribe the circumstances under which the county DEPARTMENT or designated service agency may continue benefits if an appeal is filed after the effective date of the intended action. At a minimum, the rules must allow for continuing benefits when the ~~recipient's~~ MEMBER'S health or safety is impacted, the ~~recipient~~ MEMBER was not able to timely respond due to the ~~recipient's~~ MEMBER'S disability or employment, the ~~recipient's~~ MEMBER'S caregiver was unavailable due to the caregiver's health or employment, or the ~~recipient~~ MEMBER did not receive the ~~county's~~ COUNTY DEPARTMENT'S or designated service agency's notice prior to the effective date of the intended action.

(III) Either prior to appeal or as part of the filing of an appeal, the applicant or ~~recipient~~ MEMBER may request the dispute resolution process described in ~~paragraph (b) of this subsection (1)~~ SUBSECTION (1)(b) OF THIS SECTION through the county department or service delivery agency.

(b) Every county department or service delivery agency shall adopt procedures for the resolution of disputes arising between the county

department or the service delivery agency and any applicant for or ~~recipient~~ MEMBER of medical assistance. ~~Such~~ THE procedures are referred to in this section as the "dispute resolution process". Two or more counties may jointly establish the dispute resolution process. The dispute resolution process must be consistent with rules promulgated by the state board pursuant to article 4 of title 24. ~~C.R.S.~~ The dispute resolution process ~~shall~~ MUST include an opportunity for all ~~clients~~ MEMBERS to have a county DEPARTMENT conference, upon the ~~client's~~ MEMBER'S request, and ~~such~~ THE requirement may be met through a telephonic conference upon the agreement of the ~~client~~ MEMBER and the county department. The dispute resolution process ~~need not~~ DOES NOT NEED TO conform to the requirements of section 24-4-105 ~~C.R.S.,~~ as long as the rules adopted by the state board include provisions specifically setting forth expeditious time frames, notice, and an opportunity to be heard and to present information. If the dispute is resolved through the county DEPARTMENT or service delivery agency's dispute resolution process and the applicant or ~~recipient~~ MEMBER has already filed an appeal, the county DEPARTMENT shall inform the applicant or ~~recipient~~ MEMBER of the process for dismissing the appeal.

(c) The state board shall adopt rules setting forth what other issues, if any, may be appealed by an applicant or ~~recipient~~ MEMBER to the state department. THE STATE DEPARTMENT IS NOT REQUIRED TO GRANT a hearing ~~need not be granted~~ when either state or federal law requires or results in a reduction or deletion of a medical assistance benefit unless the applicant or ~~recipient~~ MEMBER is arguing that ~~his or her~~ THE APPLICANT'S OR MEMBER'S case does not fit within the parameters set forth by the change in the law. In notifying the applicant or ~~recipient~~ MEMBER that an

appeal is being denied because of a change in state or federal law, the ~~state's~~ STATE DEPARTMENT'S notice must inform the applicant or ~~recipient~~ MEMBER that further appeal should be directed to the appropriate state or federal court.

(d.5) (I) At the commencement of a hearing that concerns the termination or reduction of an existing benefit, the state department's administrative law judge shall review the legal sufficiency of the notice of action from which the ~~recipient~~ MEMBER is appealing. If the administrative law judge determines that the notice is legally insufficient, the administrative law judge shall inform the appellant that the termination or reduction may be set aside on the basis of insufficient notice without proceeding to a hearing on the merits. The appellant may affirmatively waive the defense of insufficient notice and agree to proceed with a hearing on the merits or may ask the administrative law judge to decide the appeal on the basis of ~~his or her~~ THE JUDGE'S finding that the notice is legally insufficient. The administrative law judge shall also inform the appellant that the state department may issue legally sufficient notice in the future and that the state department may seek recoupment of benefits if a basis for denial or reduction of benefits is subsequently determined.

SECTION 25. In Colorado Revised Statutes, 25.5-4-209, **amend** (1)(a), (1)(b), (3)(a), and (3)(d) as follows:

25.5-4-209. Payments by third parties - copayments by members - review - appeal - children's waiting list reduction fund - rules - repeal. (1) (a) Any ~~recipient~~ MEMBER receiving benefits ~~under this article~~ PURSUANT TO THIS ARTICLE 4 or article 5 or 6 of this ~~title~~ TITLE 25.5 who receives any supplemental income, available for medical

purposes under rules of the state department, or who receives proceeds from sickness, accident, health, or casualty insurance, ~~shall~~ MUST apply the supplemental income or insurance proceeds to the cost of the benefits rendered, and the STATE DEPARTMENT rules may require reports from providers of other payments received ~~by them~~ from or on behalf of ~~recipients~~ MEMBERS.

(b) Subject to any limitations imposed by Title XIX OF THE FEDERAL "SOCIAL SECURITY ACT", a ~~recipient~~ MEMBER shall pay at the time of service a portion of the cost of any medical benefit rendered to the ~~recipient~~ MEMBER or to the ~~recipient's~~ MEMBER'S dependents pursuant to this article 4 or article 5 or 6 of this title 25.5, as determined by rules of the state department.

(3) (a) The rights assigned by a ~~recipient~~ MEMBER of medical assistance to the state department pursuant to section 25.5-4-205 (4) ~~shall~~ MUST include the right to appeal an adverse coverage decision by a third party for which the medical assistance program may be responsible for payment, including but not limited to the internal and external reviews ~~provided for~~ DESCRIBED in sections 10-16-113 and 10-16-113.5 ~~C.R.S.,~~ and a third party's reasonable appeal procedure under state and federal law. The state department or the independent contractor retained pursuant to ~~paragraph (b) of this subsection (3)~~ SUBSECTION (3)(b) OF THIS SECTION shall review and, if necessary, may appeal at any level an adverse coverage decision, except an adverse coverage decision relating to medicare, Title XVIII of the federal "Social Security Act", as amended.

(d) Nothing in this subsection (3) ~~shall be construed to authorize~~ AUTHORIZES the denial of or delay of payment to a provider by the state department or the delay or interference with the provision of services to

a medical assistance ~~recipient~~ MEMBER.

SECTION 26. In Colorado Revised Statutes, **amend** 25.5-4-210 as follows:

25.5-4-210. Purchase of health insurance for members. (1) (a) The state department shall purchase group health insurance for a medical assistance ~~recipient~~ MEMBER who is eligible to enroll for ~~such~~ coverage if enrollment of ~~such recipient~~ THE MEMBER in the group plan would be cost-effective. In addition, the state department may purchase individual health insurance for a medical assistance ~~recipient~~ MEMBER who is eligible to enroll in a health insurance plan if enrollment of ~~such recipient~~ THE MEMBER would be cost-effective to this state. A determination of cost-effectiveness ~~shall~~ MUST be in accordance with federal guidelines established by the secretary of the ~~United States~~ FEDERAL department of health and human services.

(b) Notwithstanding any provision of ~~paragraph (a) of this subsection (1)~~ SUBSECTION (1)(a) OF THIS SECTION to the contrary, the state department, in purchasing health insurance for medical assistance ~~recipients~~ MEMBERS who are eligible to enroll for private coverage, shall not purchase ~~such~~ health insurance for more than two thousand individuals.

(2) Enrollment in a group health insurance plan ~~shall be~~ IS required of ~~recipients~~ MEMBERS for whom enrollment has been determined to be cost-effective as a condition of obtaining or retaining medical assistance. A parent ~~shall be~~ IS __ required to enroll a dependent child ~~recipient~~ MEMBER, but medical assistance for ~~such~~ THE child ~~shall not be~~ IS NOT discontinued if a parent fails to enroll the child.

(3) The state department shall pay any premium, deductible,

coinsurance, or other cost-sharing obligation required under the group plan for services covered under the state medical assistance plan. In addition, the state department shall pay any premium, deductible, coinsurance, or other cost-sharing obligation required under an individual plan purchased by the state department for a medical assistance ~~recipient~~ MEMBER pursuant to subsection (1) of this section. Payment of ~~said~~ THE services ~~shall be~~ ARE treated as payment for medical assistance. Coverage provided by the purchased health insurance plan ~~shall be~~ IS considered ~~as~~ third-party liability for the purposes of section 25.5-4-209.

(4) Services not available to a ~~recipient~~ MEMBER under the purchased plan ~~shall be~~ ARE provided to the ~~recipient if such~~ MEMBER IF THE services would otherwise be provided as medical assistance services pursuant to this ~~article~~ ARTICLE 4 or article 5 or 6 of this ~~title~~ TITLE 25.5. Nothing in this section ~~shall be construed to require that~~ REQUIRES services provided under a group health insurance plan for medical assistance ~~recipients shall~~ TO be made available to ~~recipients~~ MEMBERS not enrolled in the plan. Enrollment in a group health insurance plan pursuant to this section ~~shall~~ DOES not affect the eligibility of a ~~recipient~~ MEMBER who otherwise qualifies for medical assistance pursuant to this ~~article~~ ARTICLE 4 or article 5 or 6 of this ~~title~~ TITLE 25.5.

SECTION 27. In Colorado Revised Statutes, **amend** 25.5-4-212 as follows:

25.5-4-212. Medicaid member correspondence improvement process - legislative declaration - definition. (1) (a) The general assembly finds and declares that:

(I) Accurate, understandable, timely, informative, and clear correspondence from the state department is critical to the life and health

of medicaid ~~recipients,~~ MEMBERS AND APPLICANTS and, in some cases, is a matter of life and death for our most vulnerable populations;

(II) Unclear, confusing, and late correspondence from the state department causes an increased workload for the state, counties administering the medicaid program, and nonprofit advocacy groups assisting ~~clients~~ APPLICANTS AND MEMBERS; and

(III) Government should be a good steward of taxpayers' money, ensuring that it is spent in the most cost-effective manner.

(b) Therefore, the general assembly finds that improving medicaid ~~client~~ MEMBER correspondence is critical to the health and safety of medicaid ~~clients~~ MEMBERS and will reduce unnecessary confusion that requires ~~clients~~ MEMBERS to call counties and the state department or file appeals.

(2) As used in this section, unless the context otherwise requires, "~~client~~ MEMBER correspondence" means any communication ~~the purpose of which is~~ to provide notice of an approval, denial, termination, or change to an individual's medicaid eligibility; to provide notice of the approval, denial, reduction, suspension, or termination of a medicaid benefit; or to request additional information that is relevant to determining an individual's medicaid eligibility or benefits. ~~Client~~ "MEMBER correspondence" does not include communications regarding the state department's review of trusts or review of documents or records relating to trusts.

(3) The state department shall improve medicaid ~~client~~ MEMBER correspondence by ensuring that ~~client~~ MEMBER correspondence revised or created after January 1, 2018:

(a) Is written using person-first, plain language;

(b) Is written in a format that includes the date of the correspondence and a ~~client~~ MEMBER greeting;

(c) Is consistent, using the same terms throughout to the extent practicable, including commonly used program names;

(d) Is accurately translated into the second most commonly spoken language in the state if a ~~client~~ MEMBER indicates that ~~this~~ THE LANGUAGE is the ~~client's~~ MEMBER'S written language of preference or as required by law;

(e) Includes a statement translated into the top fifteen languages most commonly spoken by individuals in Colorado with limited English proficiency informing an applicant or ~~client~~ MEMBER how to seek further assistance in understanding the content of the correspondence;

(f) Clearly conveys the purpose of the ~~client~~ APPLICANT OR MEMBER correspondence, the action or actions being taken by the state department or ~~its~~ THE STATE DEPARTMENT'S designated entity, if any, and the specific action or actions that the ~~client must~~ APPLICANT OR MEMBER SHALL or may take in response to the correspondence;

(g) Includes a specific description of any necessary information or documents requested from the applicant or ~~client~~ MEMBER;

(h) Includes contact information for ~~client~~ APPLICANT OR MEMBER questions; and

(i) Includes a specific and plain language explanation of the basis for the denial, reduction, suspension, or termination of the benefit, if applicable.

(4) Subject to the availability of sufficient appropriations and receipt of federal financial participation, on and after July 1, 2018, the state department shall make electronically available to a ~~client~~ MEMBER

specific and detailed information concerning the ~~client's~~ MEMBER'S household composition, assets, income sources, and income amounts, if relevant to a determination for which ~~client~~ MEMBER correspondence was issued. If implemented, the state department shall notify ~~clients~~ MEMBERS in the written correspondence of the option to access this information.

(5) The state department is encouraged to promote the receipt of ~~client~~ MEMBER correspondence electronically or through mobile applications for ~~clients~~ MEMBERS who choose those methods of delivery as allowed by law.

(6) As part of its ongoing process to create and improve ~~client~~ MEMBER correspondence, the state department may engage with experts in written communication and plain language to test ~~client~~ MEMBER correspondence against the criteria set forth in subsection (3) of this section with a geographically diverse and representative sample of medicaid ~~clients~~ MEMBERS relevant to the ~~client~~ MEMBER correspondence being revised. The state department shall also develop a process to review and consider feedback from stakeholders including ~~client~~ CONSUMER advocates and counties prior to implementing significant changes to correspondence.

(7) The state department shall ensure that ~~client~~ APPLICANT OR MEMBER correspondence that may only affect a small number of ~~clients~~ APPLICANTS OR MEMBERS, but may, nonetheless, have a significant impact on the lives of those ~~clients~~ APPLICANTS OR MEMBERS, is appropriately prioritized for revision.

(8) As part of its annual presentation made to its legislative committee of reference pursuant to section 2-7-203, the state department shall present information concerning:

(a) ~~Its~~ THE STATE DEPARTMENT'S process for ongoing improvement of ~~client~~ MEMBER correspondence;

(b) ~~Client~~ MEMBER correspondence revised pursuant to criteria set forth in subsection (3) of this section during the prior year and ~~client~~ MEMBER correspondence improvements that are planned for the upcoming year; and

(c) A description of the results of testing of new or significantly revised ~~client~~ MEMBER correspondence pursuant to subsection (6) of this section, including a description of the stakeholder feedback.

SECTION 28. In Colorado Revised Statutes, **amend** 25.5-4-213 as follows:

25.5-4-213. Audit of medicaid member correspondence - definition. (1) As used in this section, unless the context otherwise requires, "~~client~~ MEMBER correspondence" has the same meaning as defined in section 25.5-4-212.

(2) During the 2020 calendar year and the 2023 calendar year, the office of the state auditor shall conduct or cause to be conducted a performance audit of ~~client~~ MEMBER correspondence. Thereafter, the state auditor, in the exercise of ~~his or her~~ THE STATE AUDITOR'S discretion, may conduct or cause to be conducted additional performance audits of ~~client~~ MEMBER correspondence pursuant to this section. The audit ~~shall~~ MUST include correspondence generated through the Colorado benefits management system, as well as correspondence that is not generated through the Colorado benefits management system.

(3) The performance audit conducted pursuant to this section ~~shall~~ MUST include:

(a) A review of available data from counties, FROM the STATE

department's customer service contract center, and from assistors within the health benefit exchange, created in article 22 of title 10, regarding customer service contacts that are related to ~~client~~ MEMBER OR APPLICANT confusion regarding correspondence received by medicaid ~~clients~~ MEMBERS or applicants;

(b) A review of the accuracy of ~~client~~ MEMBER correspondence at the time ~~it~~ THE CORRESPONDENCE is generated;

(c) A review of whether ~~client~~ MEMBER correspondence satisfies the requirements of any state or federal law, rule, or regulation relating to the sufficiency of any notice;

(d) A review of any ~~client~~ MEMBER correspondence testing process conducted by the STATE department and whether testing is done prior to implementing new or significantly revised ~~client communications~~ MEMBER CORRESPONDENCE;

(e) A review of the results of any ~~client~~ MEMBER correspondence testing, including ~~client~~ MEMBER comprehension of the intended purpose or purposes of the correspondence; and

(f) A review of the accuracy of ~~client~~ MEMBER income and household composition information that is communicated electronically, if applicable.

(4) If audit findings include findings that information contained in ~~client~~ MEMBER correspondence is inaccurate at the time the correspondence was generated, the audit ~~shall~~ MUST identify, if possible, the source of the inaccurate information, which may include but is not limited to computer system or interface issues, county input error, or applicant error.

(5) Based on the findings and conclusions identified during the

performance audit conducted pursuant to this section, the office of the state auditor shall make recommendations to the state department for improving ~~client~~ MEMBER correspondence. On or before December 30, 2020, December 30, 2023, and December 30 in any calendar year in which an audit is conducted pursuant to this section, the office of the state auditor shall submit the findings, conclusions, and recommendations from the performance audit in the form of a written report to the legislative audit committee, which shall hold a public hearing for the purposes of ~~a review of~~ REVIEWING the report. The report ~~shall~~ MUST also be submitted to the joint budget committee, the public health care and human services committee of the house of representatives, the health and human services committee of the senate, and the joint technology committee, or any successor committees.

SECTION 29. In Colorado Revised Statutes, **amend** 25.5-4-300.4 as follows:

25.5-4-300.4. Last resort for payment - legislative intent. It is the intent of the general assembly that medicaid ~~be~~ IS the last resort for payment for medically necessary goods and services furnished to ~~recipients~~ MEMBERS and that all other sources of payment are primary to medical assistance provided by medicaid.

SECTION 30. In Colorado Revised Statutes, 25.5-4-300.9, **amend** (1)(a)(VI), (1)(a)(VII), (1)(a)(VIII), (1)(b), (2), (4)(a), (4)(f), (4)(g), (4)(h), (5), (6), and (7) as follows:

25.5-4-300.9. Explanation of benefits - medicaid members - legislative declaration. (1) (a) The general assembly finds and declares that:

(VI) While creating an explanation of benefits is not without cost

to the health-care system, only the ~~client~~ MEMBER receiving medical services or ~~his or her~~ THE MEMBER'S authorized representative is in the position to verify whether the claimed medical services were actually provided and for whom they were provided, which is a necessary first step in containing health-care costs;

(VII) While medicaid ~~clients~~ MEMBERS may not appear to be affected financially by billing errors or fraudulent claims, medicaid ~~clients~~ MEMBERS who rely on these services for survival and independence are most severely affected by the inappropriate use of scarce resources; and

(VIII) Further, medicaid ~~clients~~ MEMBERS and ~~medicaid~~ CONSUMER advocates for low-income and vulnerable Coloradans want the opportunity to partner with the state department and providers to ensure a well-run and fraud-free medicaid program in Colorado.

(b) Therefore, the general assembly declares that creating an explanation of benefits for ~~recipients~~ MEMBERS of medicaid-funded services is a necessary step in managing the state's medicaid program and in safeguarding the significant public investment, both state and federal, in meeting the health-care needs of low-income and vulnerable Coloradans.

(2) ~~By~~ ON or before July 1, 2017, the state department shall develop and implement an explanation of benefits for ~~recipients~~ MEMBERS of medical services pursuant to ~~articles 4 to 6 of this title~~ THIS ARTICLE 4 AND ARTICLE 5 OR 6 OF THIS TITLE 25.5. The purpose of the explanation of benefits is to inform a medicaid ~~client~~ MEMBER of a claim for reimbursement made for services provided to the ~~client~~ MEMBER or on ~~his or her~~ THE MEMBER'S behalf, so that the ~~client~~ MEMBER may discover and

report administrative or provider errors or fraudulent claims for reimbursement.

(4) The explanation of benefits must include, at a minimum:

(a) The name of the medicaid ~~client~~ MEMBER receiving the service;

(f) A clear statement to the medicaid ~~client~~ MEMBER that the explanation of benefits is not a bill, but is only provided for the ~~client's~~ MEMBER'S information and to make sure that a provider is being reimbursed only for services actually provided;

(g) Information regarding at least one verbal and one written method for the medicaid ~~client~~ MEMBER to report errors in the explanation of benefits that are relevant to provider reimbursement; and

(h) Any other information that the state department determines is useful to the medicaid ~~client~~ MEMBER or for purposes of discovering administrative or provider error or fraud.

(5) The state department shall develop the form and content of the explanation of benefits in conjunction with medicaid ~~clients~~ MEMBERS and ~~medicaid~~ CONSUMER advocates to ensure that medicaid ~~clients~~ MEMBERS understand the information provided and the purpose of the explanation of benefits. The state department shall also work with medicaid ~~clients~~ MEMBERS and ~~medicaid~~ CONSUMER advocates to develop educational materials for the state department's website and for distribution by advocacy and nonprofit organizations that explain the process for reporting errors and encourage ~~clients~~ MEMBERS to take responsibility for reporting errors.

(6) The state department shall provide the explanation of benefits to a medicaid ~~client~~ MEMBER not less frequently than once every two

months, if services have been provided to or on behalf of the ~~client~~ MEMBER during that time period. The state department shall determine the most cost-effective means for producing and distributing the explanation of benefits to medicaid ~~clients~~ MEMBERS, which may include e-mail or web-based distribution, with mailed copies by request only. Further, the state department may include the explanation of benefits with an existing mailing or existing electronic or web-based communication to medicaid ~~clients~~ MEMBERS.

(7) Nothing in this section requires the state department to produce an explanation of benefits form if the information required to be included in the explanation of benefits pursuant to subsection (4) of this section is already included in another format that is understandable to the medicaid ~~client~~ MEMBER.

SECTION 31. In Colorado Revised Statutes, 25.5-4-301, **amend** (1), (2)(a)(II), (4), (5), (6), (7), (8), (9), (10), (11)(a), (11)(c), (12)(b), and (15)(a) as follows:

25.5-4-301. Recoveries - overpayments - penalties - interest - adjustments - liens - review or audit procedures - repeal. (1) (a) (I) Except as provided in section 25.5-4-302 and ~~subparagraph (III) of this paragraph (a), no recipient~~ SUBSECTION (1)(a)(III) OF THIS SECTION, A MEMBER or estate of the ~~recipient shall be~~ MEMBER IS NOT liable for the cost or the cost remaining after payment by medicaid, medicare, or a private insurer of medical benefits authorized by Title XIX of the ~~social security act~~ FEDERAL "SOCIAL SECURITY ACT", by this ~~title~~ TITLE 25.5, or by rules promulgated by the state board, which benefits are rendered to the ~~recipient~~ MEMBER by a provider of medical services authorized to render ~~such~~ THE service in the state of Colorado, except

those contributions required pursuant to section 25.5-4-209 (1). However, a ~~recipient~~ MEMBER may enter into a documented agreement with a provider under which the ~~recipient~~ MEMBER agrees to pay for items or services that are nonreimbursable under the medical assistance program. Under these circumstances, a ~~recipient~~ MEMBER is liable for the cost of ~~such~~ THE services and items.

(II) The provisions of ~~subparagraph (I) of this paragraph (a) shall~~ SUBSECTION (1)(a)(I) OF THIS SECTION apply regardless of whether medicaid has actually reimbursed the provider and regardless of whether the provider is enrolled in the Colorado medical assistance program.

(II.5) (A) A provider of medical services who bills or seeks collection through a third party from a ~~recipient~~ MEMBER or the estate of a ~~recipient~~ MEMBER for medical services authorized by Title XIX of the ~~social security act~~ FEDERAL "SOCIAL SECURITY ACT" in an amount in violation of subsection (1)(a)(I) of this section is liable for and subject to the following: A refund to the ~~recipient~~ MEMBER of any amount unlawfully received from the ~~recipient~~ MEMBER, plus statutory interest from the date of the receipt until the date of repayment; a civil monetary penalty of one hundred dollars for each violation of subsection (1)(a)(I) of this section; and all amounts submitted to a collection agency in the name of the medicaid ~~recipient~~ MEMBER. When determining income or resources for purposes of determining eligibility or benefit amounts for any state-funded program under this title 25.5, the state department shall exclude from consideration any money received by a ~~recipient~~ MEMBER pursuant to this subsection (1)(a)(II.5). The imposition of a civil monetary penalty by the state department may be appealed administratively.

(A.5) A provider of medical services who, within thirty days of

notification by the state department, or longer if approved by the state department, voids the bill, returns any amount unlawfully received, and makes every reasonable effort to resolve any collection actions so that the ~~recipient~~ MEMBER or the estate of the ~~recipient~~ MEMBER has no adverse financial consequences is not subject to the provisions of subsection (1)(a)(II.5)(A) of this section.

(B) In order to establish a claim for the civil monetary penalty established by subsection (1)(a)(II.5)(A) of this section, a ~~recipient~~ MEMBER or the estate of a ~~recipient~~ MEMBER, or a person acting on behalf of a ~~recipient~~ MEMBER or the estate of a ~~recipient~~ MEMBER, shall notify the state department.

(C) The provisions of this ~~subparagraph (II.5) shall~~ SUBSECTION (1)(a)(II.5) DO not apply to a long-term care facility licensed pursuant to section 25-3-101. ~~C.R.S.~~

(D) The provisions of subsection (1)(a)(II.5)(A) of this section ~~shall~~ DO not apply if a ~~recipient~~ MEMBER knowingly misrepresents ~~his or her~~ THE MEMBER'S medicaid coverage status to a provider of medical services and the provider submits documentation to the state department that the ~~recipient~~ MEMBER knowingly misrepresented ~~his or her~~ THE MEMBER'S medicaid coverage status and the documentation clearly establishes a good cause basis for granting an exception to the provider.

(III) (A) When a third party is primarily liable for the payment of the costs of a ~~recipient's~~ MEMBER'S medical benefits, prior to receiving nonemergency medical care, the ~~recipient~~ MEMBER shall comply with the protocols of the third party, including using providers within the third party's network or receiving a referral from the ~~recipient's~~ MEMBER'S primary care physician. Any ~~recipient~~ MEMBER failing to follow the third

party's protocols is liable for the payment or cost of any care or services that the third party would have been liable to pay; except that, if the third party or the service provider substantively fails to communicate the protocols to the ~~recipient~~ MEMBER, the items or services are nonreimbursable under this ~~article~~ ARTICLE 4 and articles 5 and 6 of this ~~title~~ TITLE 25.5 and the ~~recipient~~ MEMBER is not liable to the provider.

(B) A ~~recipient~~ MEMBER may enter into a written agreement with a third party or provider under which the ~~recipient~~ MEMBER agrees to pay for items provided or services rendered that are outside of the network or plan protocols. The ~~recipient's~~ MEMBER'S agreement to be personally liable for ~~such~~ nonemergency, nonreimbursable items ~~shall~~ MUST be recorded on forms approved by the state board and signed and dated by both the ~~recipient~~ MEMBER and the provider in advance of the services being rendered.

(b) ~~Recipient~~ MEMBER income applied pursuant to section 25.5-4-209 (1) does not disqualify any ~~recipient~~ MEMBER, as defined in section 26-2-103 (8), from receiving benefits pursuant to this article 4, article 5 or 6 of this title 25.5, or public assistance pursuant to article 2 of title 26, and does not disqualify an individual from receiving child care assistance pursuant to part 1 of article 4 of title 26.5. If, at any time during the continuance of medical benefits, the ~~recipient~~ MEMBER ~~becomes possessed~~ GAINS POSSESSION of property having a value in excess of that amount set by law or by the rules of the state department or receives any increase in income, ~~it is the duty of the recipient to~~ THE MEMBER SHALL notify the county department ~~thereof,~~ and the county department may, after investigation, either revoke ~~such~~ THE medical benefits or alter the amount ~~thereof~~ OF MEDICAL BENEFITS, as the circumstances may require.

(c) Any medical assistance paid to which a ~~recipient~~ MEMBER was not lawfully entitled ~~shall be~~ IS recoverable from the ~~recipient~~ MEMBER or the estate of the ~~recipient~~ MEMBER by the county as a debt due the state pursuant to section 25.5-1-115, but no lien may be imposed against the property of a ~~recipient~~ MEMBER on account of medical assistance paid or to be paid on the ~~recipient's~~ MEMBER'S behalf under this ~~article~~ ARTICLE 4 or article 5 or 6 of this ~~title~~ TITLE 25.5, except pursuant to the judgment of a court of competent jurisdiction or as provided by section 25.5-4-302.

(d) If any ~~such~~ medical assistance was obtained fraudulently, interest ~~shall~~ MUST be charged and paid to the county department on the amount of ~~such~~ THE medical assistance calculated at the legal rate and calculated from the date that payment for medical services rendered on behalf of the ~~recipient~~ MEMBER is made to the date ~~such~~ THE amount is recovered.

(2) Any overpayment to a provider, including those of personal needs funds made pursuant to section 25.5-6-206, are recoverable regardless of whether the overpayment is the result of an error by the state department, a county department of human or social services, an entity acting on behalf of either department, or by the provider or any agent of the provider as follows:

(a) (II) If the state department makes a determination that ~~such~~ THE overpayment has been made for some other reason than a false representation by the provider specified in ~~subparagraph (I) of this paragraph (a)~~ SUBSECTION (2)(a)(I) OF THIS SECTION, the state department may collect the amount of overpayment, plus interest accruing at the statutory rate from the date the provider is notified of ~~such~~ THE overpayment, by the means specified in this subsection (2). Pursuant to

the criteria established in rules promulgated by the state board, the state department may waive the recovery or adjustment of all or part of the overpayment and accrued interest specified in this ~~subparagraph (II)~~ SUBSECTION (2)(a)(II) if it would be inequitable, uncollectible or administratively impracticable; except that no action shall be taken against a ~~recipient~~ MEMBER of medical services initially determined to be eligible pursuant to section 25.5-4-205 if the overpayment occurred through no fault of the ~~recipient~~ MEMBER. Amounts remaining uncollected for more than five years after the last repayment was made may be considered uncollectible.

(4) If medical assistance is furnished to or on behalf of a ~~recipient~~ MEMBER pursuant to the provisions of this ~~article~~ ARTICLE 4 and articles 5 and 6 of this ~~title~~ TITLE 25.5 for which a third party is liable, the state department has an enforceable right against ~~such~~ THE third party for the amount of ~~such~~ medical assistance, including the lien right specified in subsection (5) of this section. Whenever the ~~recipient~~ MEMBER has brought or may bring an action in court to determine the liability of the third party, the state department, without any other name, title, or authority to enforce the state department's right, may enter into appropriate agreements and assignments of rights with the ~~recipient~~ MEMBER and the ~~recipient's~~ MEMBER'S attorney, if any. Any ~~such~~ agreement ~~shall~~ MUST be filed with the court in which ~~such an~~ THE action is pending. The attorney named in ~~such an~~ THE agreement upon designation as a special assistant attorney general by the attorney general shall ~~have the right to~~ prove both the ~~recipient's~~ MEMBER'S claim and the state department's claim. The state department, without any other name, title, or authority, may take any necessary action to determine the

existence and amount of the state department's claims under this section, whether ~~such~~ THE claims are founded on judgment, contract, lien, or otherwise, and take any other action that is appropriate to recover from ~~such~~ third parties. To enforce ~~such~~ THE right, the attorney general, pursuant to section 24-31-101, ~~C.R.S.,~~ on behalf of the state department may institute and prosecute, or intervene of right in legal proceedings against the third party having legal liability, either in the name of the state department or in the name of the ~~recipient or his or her~~ MEMBER OR THE MEMBER'S assignee, guardian, personal representative, estate, or survivors. When the state department intervenes in legal proceedings against the third party, ~~it shall~~ THE STATE DEPARTMENT IS not ~~be~~ liable for any portion of the attorney fees or costs of the ~~recipient~~ MEMBER.

(5) (a) When the state department has furnished medical assistance to or on behalf of a ~~recipient~~ MEMBER pursuant to the provisions of this ~~article, and~~ ARTICLE 4 OR articles 5 and 6 of this ~~title~~ TITLE 25.5, for which a third party is liable, the state department ~~shall have~~ HAS an automatic statutory lien for all ~~such~~ medical assistance. The state department's lien ~~shall be~~ IS against any judgment, award, or settlement in a suit or claim against ~~such~~ THE third party and ~~shall be~~ IS in an amount that ~~shall be~~ IS the fullest extent allowed by federal law as applicable in this state, but not to exceed the amount of the medical assistance provided.

(b) No judgment, award, or settlement in any action or claim by a ~~recipient~~ MEMBER to recover damages for injuries, ~~where~~ IN WHICH the state department has a lien, ~~shall be~~ IS satisfied without first satisfying the state department's lien. Failure by any party to the judgment, award, or settlement to comply with this section ~~shall make~~ MAKES each ~~such~~ party

liable for the full amount of medical assistance furnished to or on behalf of the ~~recipient~~ MEMBER for the injuries that are the subject of the judgment, award, or settlement.

(c) Except as otherwise provided in this ~~article~~ ARTICLE 4, the entire amount of any judgment, award, or settlement of the ~~recipient's~~ MEMBER'S action or claim, with or without suit, regardless of how characterized by the parties, ~~shall be~~ IS subject to the state department's lien.

(d) ~~Where~~ WHEN the action or claim is brought by the ~~recipient~~ MEMBER alone and the ~~recipient~~ MEMBER incurs a personal liability to pay attorney fees, the state department ~~will~~ SHALL pay ~~its~~ THE STATE DEPARTMENT'S reasonable share of attorney fees not to exceed twenty-five percent of the state department's lien. The state department ~~shall not be~~ IS NOT liable for costs.

(e) The state department's right to recover under this section is independent of the ~~recipient's~~ MEMBER'S right.

(6) When the applicant or ~~recipient~~ MEMBER, or ~~his or her~~ THE APPLICANT'S OR MEMBER'S guardian, executor, administrator, or other appropriate representative, brings an action or asserts a claim against any third party, ~~such~~ THE person shall give ~~to~~ the state department written notice of the action or claim by personal service or certified mail within fifteen days after filing the action or asserting the claim. Failure to comply with this subsection (6) ~~shall make~~ MAKES the ~~recipient~~ MEMBER, legal guardian, executor, administrator, attorney, or other representative liable for the entire amount of medical assistance furnished to or on behalf of the ~~recipient~~ MEMBER for the injuries that gave rise to the action or claim. The state department may, after thirty days' written notice to

~~such~~ THE person, enforce ~~its~~ THE STATE DEPARTMENT'S rights under subsection (5) of this section and this subsection (6) in the district court of the city and county of Denver; except that liability of a person other than the ~~recipient shall exist~~ MEMBER EXISTS only if ~~such~~ THE person had knowledge that the ~~recipient~~ MEMBER had received medical assistance or if excusable neglect is found by the court. The court shall award the state department its costs and attorney fees incurred in the prosecution of any such action.

(7) When a legally responsible relative of the ~~recipient~~ MEMBER agrees or is ordered to provide medical support or health insurance coverage for ~~his or her~~ THE MEMBER'S dependents or other persons, and ~~such~~ THE dependents are applicants for, ~~recipients~~ MEMBERS of, or otherwise entitled to receive medical assistance pursuant to this ~~article~~ ARTICLE 4 and articles 5 and 6 of this ~~title~~ TITLE 25.5, the state department ~~shall be~~ IS subrogated to any rights that the responsible persons may have to obtain reimbursement from a third party or insurance carrier for the cost of medical assistance provided for such dependents or persons. ~~Where~~ WHEN the state department gives written notice of subrogation, any third party or insurance carrier liable for reimbursement for the cost of medical care shall accord to the state department all rights and benefits available to the responsible relative that pertain to the provision of medical care to any persons entitled to medical assistance pursuant to this ~~article~~ ARTICLE 4 and articles 5 and 6 of this ~~title~~ TITLE 25.5 for whom the relative is legally responsible.

(8) All ~~recipients~~ MEMBERS of medical assistance under the medicaid program ~~shall be~~ ARE deemed to have authorized ~~their~~ THE MEMBER'S attorneys, all third parties, including but not limited to

insurance companies, and providers of medical care to release to the state department all information needed by the state department to secure and enforce its rights under subsections (4) and (5) of this section.

(9) Nothing in part 6 of article 4 of title 10 ~~C.R.S., shall be construed to limit~~ LIMITS the right of the state department to recover the medical assistance furnished to or on behalf of a ~~recipient~~ MEMBER as the result of the negligence of a third party.

(10) No action taken by the state department pursuant to subsection (4) of this section or any judgment rendered in ~~such action shall be a bar to~~ THE ACTION BARS any action upon the claim or cause of action of the applicant or ~~recipient~~ MEMBER or ~~his or her~~ THE MEMBER'S guardian, personal representative, estate, dependent, or survivors against the third party having legal liability, nor shall any ~~such~~ action or judgment operate to deny the applicant or ~~recipient~~ MEMBER the recovery for that portion of ~~his or her~~ THE MEMBER'S medical costs or other damages not provided as medical assistance under this ~~article~~ ARTICLE 4 or article 5 or 6 of this ~~title~~ TITLE 25.5.

(11) (a) The state department ~~shall have a right to~~ MAY recover any amount of medical assistance paid on behalf of a ~~recipient~~ MEMBER because:

(I) The trustee of a trust for the benefit of the ~~recipient~~ MEMBER has used the trust property in a manner contrary to the terms of the trust; OR

(II) A person holding the ~~recipient's~~ MEMBER'S power of attorney has used the power for purposes other than the benefit of the ~~recipient~~ MEMBER.

(c) No action taken by the county or state department pursuant to

this subsection (11) or any judgment rendered in ~~such~~ AN action or proceeding ~~shall be a bar to~~ BARS any action upon the claim or cause of action of the ~~recipient~~ MEMBER or ~~his or her~~ THE MEMBER'S guardian, personal representative, estate, dependent, or survivors against the trustee or person holding the power of attorney.

(12) (b) Within fifteen days after filing an action or asserting a claim against a third party, a ~~recipient~~ MEMBER under a managed care plan or a guardian, executor, administrator, or other appropriate representative of the ~~recipient~~ MEMBER shall provide to the entity that administers the managed care plan written notice of the action or claim. Notice ~~shall~~ MUST be by personal service or certified mail.

(15) (a) The state department may request a written response from any provider who fails to comply with the rules, manuals, or bulletins issued by the state department, state board, or the state department's fiscal agent, or from any provider whose activities endanger the health, safety, or welfare of medicaid ~~recipients~~ MEMBERS. The written response must describe how the provider will come into and ensure future compliance. If a written response is requested, a provider has thirty days, or longer if approved by the state department, to submit the written response.

SECTION 32. In Colorado Revised Statutes, 25.5-4-302, **amend** (1) as follows:

25.5-4-302. Recovery of assets. (1) The general assembly ~~hereby~~ finds, determines, and declares that the cost of providing medical assistance to qualified ~~recipients~~ MEMBERS throughout the state has increased significantly in recent years; that such increasing costs have created an increased burden on state revenues while reducing the amount of ~~such~~ revenues available for other state programs; that recovering some

of the medical assistance from the estates of medical assistance ~~recipients~~ MEMBERS would be a viable mechanism for ~~such recipients~~ MEMBERS to share in the cost of ~~such~~ assistance; and that ~~such~~ an estate recovery program would be a cost-efficient method of offsetting medical assistance costs in an equitable manner. The general assembly also declares that in order to ensure that medicaid is available for low-income individuals reasonable restrictions consistent with federal law should be placed on the ability of persons to become eligible for medicaid by means of making transfers of property without fair and valuable consideration.

SECTION 33. In Colorado Revised Statutes, 25.5-4-401, **amend** (1)(a), (3)(a), (3)(b)(III), and (4) as follows:

25.5-4-401. Providers - payments - rules. (1) (a) The state department shall establish rules for the payment of providers under this ~~article~~ ARTICLE 4 and articles 5 and 6 of this ~~title~~ TITLE 25.5. Within the limits of available funds, ~~such~~ THE rules ~~shall~~ MUST provide reasonable compensation to ~~such~~ providers, but no provider ~~shall~~, by this section or any other provision of this ~~article~~ ARTICLE 4 or article 5 or 6 of this ~~title, be deemed to have~~ TITLE 25.5, HAS any vested right to act as a provider under this ~~article~~ ARTICLE 4 and articles 5 and 6 of this ~~title~~ TITLE 25.5 or to receive any payment in addition to or different from that which is currently payable on behalf of a ~~recipient~~ MEMBER at the time the medical benefits are provided by ~~said~~ THE provider.

(3) (a) As used in this subsection (3), "capitated" means a method of payment by which a provider directly delivers or arranges for delivery of medical care benefits for a term established by contract with the state department based on a fixed rate of reimbursement per ~~recipient~~ MEMBER.

(b) (III) The state department may define groups of ~~recipients~~

MEMBERS by geographic area or other categories and may require that all members of the defined group obtain medical services through one or more provider contracts entered into pursuant to this subsection (3).

(4) (a) The general assembly ~~hereby~~ finds, determines, and declares that access to health-care services would be improved and costs of health care would be restrained if the ~~recipients~~ MEMBERS of the medicaid program would choose a primary care physician through a managed care provider. For purposes of this subsection (4), "managed care provider" means either a primary care physician program, a health maintenance organization, or a prepaid health plan.

(b) Subject to the provisions of ~~paragraph (c) of this subsection (4)~~ SUBSECTION (4)(c) OF THIS SECTION, the executive director of the state department has the authority to require a ~~recipient~~ MEMBER of the medicaid program to select a managed care provider and to assign a ~~recipient~~ MEMBER to a managed care provider if the ~~recipient~~ MEMBER has failed to make a selection within a reasonable time. To the extent possible, this requirement ~~shall~~ MUST be implemented on a statewide basis.

(c) The state department shall ensure the following:

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

(II) All ~~recipients~~ MEMBERS shall be adequately informed about AVAILABLE service delivery options ~~available to them~~ consistent with the

provisions of this ~~subparagraph (II)~~ SUBSECTION (4)(c)(II). If a ~~recipient~~ MEMBER does not respond to a state department request for selection of a delivery option ~~within~~ AFTER forty-five calendar days, the state department shall send a second notification to the ~~recipient~~ MEMBER. If the ~~recipient~~ MEMBER does not respond ~~within~~ AFTER twenty days of the date of the second notification, the state department shall ensure that the ~~recipient~~ MEMBER remains with the ~~recipient's~~ MEMBER'S primary care physician, regardless of whether ~~said~~ THE primary care physician is enrolled in a health maintenance organization.

SECTION 34. In Colorado Revised Statutes, 25.5-4-401.5, **amend** (2)(a), (2)(d)(II), (2)(e) introductory portion, (2)(e)(II) introductory portion, and (3)(a)(III) as follows:

25.5-4-401.5. Review of provider rates - advisory committee - recommendations - repeal. (2) (a) In the first phase of the review process, the state department shall conduct an analysis of the access, service, quality, and utilization of each service subject to a provider rate review. The state department shall compare the rates paid with available benchmarks, including medicare rates and usual and customary rates paid by private pay parties, and use qualitative tools to assess whether payments are sufficient to allow for provider retention and ~~client~~ MEDICAID MEMBER access and to support appropriate reimbursement of high-value services.

(d) (II) The state department shall submit, as part of the report required pursuant to this subsection (2)(d), a description of the information discussed during the quarterly public meeting; the state department's response to the public comments received from providers, ~~recipients~~ MEMBERS, and other interested parties; and an explanation of

how the public comments informed the provider rate review process and the recommendations concerning provider rates.

(e) The state department shall conduct a public meeting at least quarterly to inform the state department's review of provider rates paid under the "Colorado Medical Assistance Act". The state department shall invite to the public meeting providers, ~~recipients~~ MEMBERS, and other interested parties directly affected by the services scheduled to be reviewed at the public meeting. At a minimum, each public meeting must consist of, but is not limited to:

(II) Public comments from providers, ~~recipients~~ MEMBERS, and other interested parties concerning:

(3) (a) There is created in the state department the medicaid provider rate review advisory committee, referred to in this section as the "advisory committee", to assist the state department in the review of the provider rate reimbursements under the "Colorado Medical Assistance Act". The advisory committee shall:

(III) Review the comments received from providers, ~~recipients~~ MEMBERS, and other interested parties and the state department's response to the comments required pursuant to subsection (2)(d)(II) of this section;

SECTION 35. In Colorado Revised Statutes, 25.5-4-402, **amend** (4)(c)(II) and (4)(d)(I); and **repeal** (4)(d)(IV) and (4)(d)(V) as follows:

25.5-4-402. Providers - hospital reimbursement - hospital review program - rules. (4) (c) The following factors must be considered in any coverage determinations made pursuant to the hospital review programs:

(II) Evidence-based clinical coverage criteria and ~~recipient~~ MEMBER coverage guidelines as established by the state department;

(d) (I) The state department shall consult with affected stakeholders prior to implementation of the hospital review program. At a minimum, the state department shall solicit feedback from ~~recipients~~ MEMBERS, hospitals within Colorado that participate in medicaid, providers participating in the accountable care collaborative pursuant to section 25.5-5-419, and the Colorado healthcare affordability and sustainability enterprise board established in section 25.5-4-402.4 (7). If the state department contracts with a third-party vendor to implement the hospital review program, the state department shall require the vendor to participate in the stakeholder outreach with hospitals required pursuant to this subsection (4)(d)(I).

(IV) ~~The state department shall provide a report to the joint budget committee on November 1, 2019, and November 1, 2020, detailing the estimates of the cost savings achieved and the impact of the cost-control measures authorized pursuant to this section on recipients and recipients' health outcomes.~~

(V) ~~Beginning in 2018, and every year thereafter through 2020, the state department shall report on the status of the implementation of the hospital review program, any cost savings estimated or achieved due to the program, and the impact on recipients and recipients' outcomes of any cost-control measures as part of its "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act" hearing required by section 2-7-203.~~

SECTION 36. In Colorado Revised Statutes, **amend** 25.5-4-405 as follows:

25.5-4-405. Mental health managed care service providers - requirements. (1) Each contract between the state department and a

managed care organization providing mental health services to a ~~recipient~~ MEMBER under the medical assistance program ~~shall~~ MUST comply with all federal requirements, including but not limited to:

(a) Ensuring that a ~~recipient~~ MEMBER with complex or multiple needs who requires mental health services ~~shall have~~ HAS access to mental health professionals with appropriate training and credentials and ~~shall provide~~ PROVIDING the ~~recipient~~ MEMBER with ~~such~~ THE services in collaboration with the ~~recipient's~~ MEMBER'S other providers;

(b) Informing each ~~recipient of his or her~~ MEMBER OF THE MEMBER'S right to and the process for appeal upon notification of denial, termination, or reduction of a requested service; and

(c) Administering initial stabilization treatment for a ~~recipient~~ MEMBER and transferring the ~~recipient~~ MEMBER for appropriate continued services.

(1.5) Each contract between the state department and a managed care organization providing mental health services to a ~~recipient~~ MEMBER under the medical assistance program ~~shall~~ MUST allow for the use of telemedicine pursuant to ~~the provisions of~~ section 25.5-5-320.

(2) For mental health managed care ~~recipients~~ MEMBERS, the state department shall have a patient representative program for ~~recipient~~ MEMBER grievances that complies with all federal requirements and that ~~shall~~ MUST:

(a) Be posted in a conspicuous place at each location at which mental health services are provided;

(b) Allow for a patient representative to serve as a liaison between the ~~recipient~~ MEMBER and the provider;

(c) Describe the qualifications for a patient representative;

(d) Outline the responsibilities of a patient representative;

(e) Describe the authority of a patient representative; and

(f) Establish a method by which each ~~recipient~~ MEMBER is informed of the patient representative program and how a patient representative may be contacted.

SECTION 37. In Colorado Revised Statutes, 25.5-4-412, **amend** (5) as follows:

25.5-4-412. Family planning services - family-planning-related services - rules - definitions. (5) Any ~~recipient~~ MEMBER may obtain family planning services or family-planning-related services from any licensed health-care provider, including a doctor of medicine, doctor of osteopathy, physician assistant, advanced practice registered nurse, or certified midwife who provides such services. The enrollment of a ~~recipient~~ MEMBER in a managed care organization, or a similar entity, does not restrict a ~~recipient's~~ MEMBER'S choice of the licensed provider from whom the ~~recipient~~ MEMBER may receive those services.

SECTION 38. In Colorado Revised Statutes, 25.5-4-416, **amend** (1) and (2)(a)(III) as follows:

25.5-4-416. Providers - medical equipment and supplies - requirements. (1) As used in this section, unless the context otherwise requires, "provider" means a person or entity that delivers disposable medical supplies or durable medical equipment products or services directly to a ~~recipient~~ MEMBER.

(2) On and after January 1, 2007, the state board rules for the payment for disposable medical supplies and durable medical equipment, including but not limited to prosthetic and orthotic devices, shall prohibit a provider from being reimbursed unless the provider:

(a) (III) Is responsible for the delivery of and instructing the ~~recipient~~ MEMBER on the proper use of the equipment; and

SECTION 39. In Colorado Revised Statutes, 25.5-4-422, **amend** (4)(b); and **repeal** (5)(c) and (6)(b) as follows:

25.5-4-422. Cost control - legislative intent - use of technology - stakeholder feedback - reporting - rules. (4) (b) Prior to implementing and reporting on any new measures authorized by this section, the state department shall provide an opportunity for affected ~~recipients~~ MEMBERS, providers, and stakeholders to provide feedback and make recommendations on the state department's proposed implementation.

(5) By November 1, 2018, the state department shall provide a report to the joint budget committee concerning:

(c) ~~A description of the expected impact on recipients and recipients' health outcomes and how the state department plans to measure the effect on recipients.~~

(6) (b) ~~The state department shall provide a report to the joint budget committee on November 1, 2019, and November 1, 2020, detailing the results of the independent evaluation, including estimates of the cost savings achieved and the impact of the cost-control measures authorized pursuant to this section on recipients and recipients' health outcomes.~~

SECTION 40. In Colorado Revised Statutes, 25.5-4-428, **amend** (1), (2)(a), (2)(c), (3), and (5)(a) as follows:

25.5-4-428. Prior authorization for a step-therapy exception - rules - definition. (1) As used in this section, unless the context otherwise requires, "step therapy" means a protocol that requires a

~~recipient~~ MEMBER to use a prescription drug or sequence of prescription drugs, other than the drug that the ~~recipient's~~ MEMBER'S health-care provider recommends for the ~~recipient's~~ MEMBER'S treatment, before the state department provides coverage for the recommended prescription drug.

(2) (a) The state department shall review and determine if an exception to step therapy is granted if the prescribing provider submits a prior authorization request with justification and supporting clinical documentation for treatment of a serious or complex medical condition, if required, that states:

(I) The provider attests that the required prescription drug is contraindicated, or will likely cause intolerable side effects, a significant drug-drug interaction, or an allergic reaction to the ~~recipient~~ MEMBER;

(II) The required prescription drug lacks efficacy based on the known clinical characteristics of the ~~recipient~~ MEMBER and the known characteristics of the prescription drug regimen;

(III) The ~~recipient~~ MEMBER has tried the required prescription drug, and the use of the prescription drug by the ~~recipient~~ MEMBER was discontinued due to intolerable side effects, a significant drug-drug interaction, or an allergic reaction; or

(IV) The ~~recipient~~ MEMBER is stable on a prescription drug selected by the prescribing provider for the medical condition.

(c) If the prior authorization request for a step-therapy exception is denied, the state department shall inform the ~~recipient~~ MEMBER in writing that the ~~recipient~~ MEMBER has the right to appeal the adverse determination pursuant to state department rules.

(3) If the prior authorization request for a step-therapy exception

request is granted, the state department shall authorize coverage for the prescription drug prescribed by the ~~recipient's~~ MEMBER'S prescribing provider.

(5) This section does not prohibit:

(a) The state department from requiring a ~~recipient~~ MEMBER to try a generic equivalent of a brand name drug, a biosimilar drug as defined in 42 U.S.C. sec. 262 (i)(2), or an interchangeable biological product as defined in 42 U.S.C. sec. 262 (i)(3), unless such a requirement meets any of the criteria set forth in subsection (2)(a) of this section for an exception to step therapy and a prior authorization request is granted for the requested drug;

SECTION 41. In Colorado Revised Statutes, 25.5-4-506, **amend** (1)(b), (2) introductory portion, (3)(a), (7)(c)(III), and (7)(e) as follows:

25.5-4-506. Coverage for doula services - stakeholder process - federal authorization - scholarship program - training - report - definitions - repeal. (1) As used in this section, unless the context otherwise requires:

(b) "Maternity advisory committee" means the committee facilitated by the state department composed predominantly of Black, Indigenous, and other people of color with maternity care experience as ~~recipients~~ MEMBERS.

(2) No later than September 1, 2023, the state department shall initiate a stakeholder process to promote the expansion and utilization of doula services for pregnant and postpartum ~~recipients~~ MEMBERS in the state. In conducting the stakeholder process, the state department shall:

(3) Stakeholders must be diverse with regard to race, ethnicity, immigration status, sexual orientation, and gender, and must represent

other populations that experience greater health disparities and inequities. The state department may include the following in the stakeholder process:

(a) Doulas and potential doulas who may serve ~~recipients~~ MEMBERS who include, but are not limited to, Black, Indigenous, and other people of color, refugees, non-English speakers, people living in rural areas, and people who were recently incarcerated;

(7) (c) The state department shall define eligibility criteria for the doula scholarship program that includes, but is not limited to, the following:

(III) A statement of intent to serve as a doula provider in Colorado for pregnant and postpartum ~~recipients~~ MEMBERS.

(e) The state department may require individuals who receive scholarship money pursuant to the doula scholarship program described in this subsection (7) to submit to the state department, not later than six months after the individual's completion of doula training or certification, documentation that the individual is serving as a doula for ~~recipients~~ MEMBERS or is working toward enrollment as a doula for ~~recipients~~ MEMBERS. If an individual does not complete the documentation, the state department may seek repayment of the funds awarded to the individual through the doula scholarship program.

SECTION 42. In Colorado Revised Statutes, 25.5-5-102, **amend** (1) introductory portion and (1)(h) as follows:

25.5-5-102. Basic services for the categorically needy - mandated services. (1) Subject to the provisions of subsection (2) of this section and section 25.5-4-104, the program for the categorically needy ~~shall~~ MUST include the following services as mandated and defined by

federal law:

(h) Family planning, including a one-year supply of any federal food and drug administration-approved contraceptive drug, device, or product, unless the ~~recipient~~ MEMBER requests a supply covering a shorter period of time;

SECTION 43. In Colorado Revised Statutes, 25.5-5-103, **amend** (1)(e) as follows:

25.5-5-103. Mandated programs with special state provisions - rules. (1) This section specifies programs developed by Colorado to meet federal mandates. These programs include but are not limited to:

(e) Special provisions for the purchase of group health insurance for ~~recipients~~ MEMBERS, as specified in section 25.5-4-210;

SECTION 44. In Colorado Revised Statutes, 25.5-5-202, **amend** (1)(a)(II) as follows:

25.5-5-202. Basic services for the categorically needy - optional services. (1) Subject to the provisions of subsection (2) of this section, the following are services for which federal financial participation is available and that Colorado has selected to provide as optional services under the medical assistance program:

(a) (II) Notwithstanding ~~the provisions of subparagraph (I) of this paragraph (a)~~ SUBSECTION (1)(a)(I) OF THIS SECTION, pursuant to ~~the provisions of~~ section 25.5-5-503, prescribed drugs ~~shall not be~~ ARE NOT a covered benefit under the medical assistance program for a ~~recipient~~ MEMBER who is enrolled in a prescription drug benefit program under medicare; except that, if a prescribed drug is not a covered Part D drug as defined in the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003", Pub.L. 108-173, the prescribed drug may be

a covered benefit if it is otherwise covered under the medical assistance program and federal financial participation is available.

SECTION 45. In Colorado Revised Statutes, 25.5-5-204, **amend** (2.7)(d) as follows:

25.5-5-204. Presumptive eligibility - pregnant person - children - long-term care - state plan. (2.7) (d) If it is determined that a ~~recipient~~ MEMBER was not eligible for medical benefits after the ~~recipient~~ MEMBER had been determined to be eligible based upon presumptive eligibility, the state department shall not pursue recovery from a county department for the cost of medical services provided to the ~~recipient~~ MEMBER, and the county department shall not be responsible for any federal error rate sanctions resulting from such determination.

SECTION 46. In Colorado Revised Statutes, 25.5-5-207, **amend** (2)(a) as follows:

25.5-5-207. Adult dental benefit - adult dental fund - creation - legislative declaration. (2) (a) Pursuant to section 25.5-5-202 (1)(w), by April 1, 2014, the state department shall design and implement a limited dental benefit for adults using a collaborative stakeholder process to consider the components of the benefit, including but not limited to the cost, best practices, the effect on health outcomes, ~~client~~ MEMBER experience, service delivery models, and maximum efficiencies in the administration of the benefit.

SECTION 47. In Colorado Revised Statutes, 25.5-5-303, **amend** (2) introductory portion as follows:

25.5-5-303. Private-duty nursing. (2) A ~~recipient~~ MEMBER is eligible for private-duty nursing services if ~~he or she~~ THE MEMBER:

SECTION 48. In Colorado Revised Statutes, 25.5-5-316, **amend**

(1) and (2) as follows:

25.5-5-316. Legislative declaration - state department - disease management programs authorization - report. (1) The general assembly finds that, because Colorado is faced with rising health-care costs and limited resources, it is necessary to seek new ways to ensure the availability of high-quality, cost-efficient care for medicaid ~~recipients~~ MEMBERS. The general assembly further finds that disease management is a patient-focused, integrated approach to providing all components of care with attention to both quality of care and total cost. In addition, the general assembly finds that this approach may include coordination of physician care with pharmaceutical and institutional care. The general assembly further finds that disease management also addresses the various aspects of a disease state, including meeting the needs of persons who have multiple chronic illnesses. The general assembly declares that the improved coordination in disease management helps to provide chronically ill patients with access to the latest advances in treatment and teaches them how to be active participants in their health care through health education, thus reducing total health-care costs.

(2) The state department, in consultation with the department of public health and environment, is authorized to develop and implement disease management programs, for fee-for-service and primary care physician program recipients, that are designed to address over- or under-utilization or the inappropriate use of services or prescription drugs and that may affect the total cost of health-care utilization by a particular medicaid ~~recipient~~ MEMBER with a particular disease or combination of diseases. The disease management programs shall target medicaid ~~recipients~~ MEMBERS who are receiving prescription drugs or services in

an amount that exceeds guidelines outlined by the state department. The state department shall not restrict a medicaid ~~recipient's~~ MEMBER'S access to the most cost-effective and medically appropriate prescription drugs or services. The state department may contract on a contingency basis for the development or implementation of the disease management programs authorized in this subsection (2).

SECTION 49. In Colorado Revised Statutes, 25.5-5-321.5, **amend** (1) as follows:

25.5-5-321.5. Telehealth - interim therapeutic restorations - reimbursement - definitions. (1) Subject to federal authorization and federal financial participation, on or after July 1, 2016, in-person contact between a health-care provider and a ~~recipient~~ MEMBER is not required under the state's medical assistance program for the diagnosis, development of a treatment plan, instruction to perform an interim therapeutic restoration procedure, or supervision of a dental hygienist performing an interim therapeutic restoration procedure. A health-care provider may provide these services through telehealth, including store-and-forward transfer, and is entitled to reimbursement for the delivery of those services via telehealth to the extent the services are otherwise eligible for reimbursement under the program when provided in person. The services are subject to the reimbursement policies developed pursuant to the state medical assistance program.

SECTION 50. In Colorado Revised Statutes, 25.5-5-322, **amend** (1)(a) and (2)(b) as follows:

25.5-5-322. Over-the-counter medications - rules. (1) (a) Subject to approval through the state budget process ~~in paragraph (b) of this subsection (1)~~ DESCRIBED IN SUBSECTION (1)(b) OF THIS

SECTION, the state board shall adopt by rule a system to allow pharmacies to be reimbursed for providing certain over-the-counter medications to ~~recipients~~ MEMBERS if prescribed by a licensed practitioner authorized to prescribe prescription drugs or, subject to the limitations contained in subsection (2) of this section, a licensed pharmacist. Over-the-counter medications subject to reimbursement pursuant to this section ~~shall~~ MUST be identified through the drug utilization review process established in section 25.5-5-506, and ~~shall be~~ ARE limited to medications that, if reimbursed, ~~shall~~ result in overall cost savings to the state.

(2) (b) When prescribing over-the-counter medications under this section, a licensed pharmacist shall consult with the ~~recipient~~ MEMBER to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health-care professionals.

SECTION 51. In Colorado Revised Statutes, 25.5-5-323, **amend** (1)(a), (1)(c), (2)(a)(I), (2)(a)(III), (2)(b), (2)(d)(III)(A), (2)(d)(III)(C), (2)(d)(IV), (2)(d)(V), (2)(d)(VI), (3) introductory portion, (3)(a), (3)(c) introductory portion, (3)(d)(I), (3)(d)(III), (3)(e), (5)(a), (6), and (7) as follows:

25.5-5-323. Complex rehabilitation technology - no prior authorization - metrics - report - rules - legislative declaration - definitions. (1) The general assembly finds and declares it is in the best interests of the people of the state of Colorado to:

(a) Continue to protect access to important technology and supporting services for eligible ~~clients~~ MEMBERS;

(c) Continue to provide supports for ~~clients~~ MEMBERS accessing complex rehabilitation technology to stay in the home or community

setting; engage in basic activities of daily living and instrumental activities of daily living, including employment; prevent institutionalization; and prevent hospitalization and other costly secondary complications; and

(2) As used in this section, unless the context otherwise requires:

(a) "Complex rehabilitation technology" means individually configured manual wheelchair systems, power wheelchair systems, adaptive seating systems, alternative positioning systems, standing frames, gait trainers, and specifically designated options and accessories classified as durable medical equipment that:

(I) Are individually configured for individuals to meet their specific and unique medical, physical, and functional needs and capacities for basic activities of daily living and instrumental activities of daily living, including employment, identified as medically necessary to promote mobility in the home and community or prevent hospitalization or institutionalization of the ~~client~~ MEMBER;

(III) Require certain services provided by a qualified complex rehabilitation technology provider to ensure appropriate design, configuration, and use of such items, including patient evaluation or assessment of the ~~client~~ MEMBER by a health-care professional, and that are consistent with the ~~client's~~ MEMBER'S medical condition, physical and functional needs and capacities, body size, period of need, and intended use.

(b) "Individually configured" means that a device has features, adjustments, or modifications specific to a ~~client~~ MEMBER that a qualified complex rehabilitation technology supplier provides by measuring, fitting, programming, adjusting, adapting, and maintaining the device so that the

device is consistent with an assessment or evaluation of the ~~client~~ MEMBER by a health-care professional and consistent with the ~~client's~~ MEMBER'S medical condition, physical and functional needs and capacities, body size, period of need, and intended use.

(d) "Qualified complex rehabilitation technology supplier" means a company or entity that:

(III) Employs at least one qualified complex rehabilitation technology professional for each location to:

(A) Analyze the needs and capacities of ~~clients~~ MEMBERS for a complex rehabilitation technology item in consultation with the evaluating clinical professionals;

(C) Provide the ~~client~~ MEMBER technology-related training in the proper use and maintenance of the selected complex rehabilitation technology items;

(IV) Has the qualified complex rehabilitation technology professional directly involved with the assessment, and determination of the appropriate individually configured complex rehabilitation technology for the ~~client~~ MEMBER, with ~~such~~ THE involvement to include seeing the ~~client~~ MEMBER visually either in person or by any other real-time means within a reasonable time frame during the determination process.

(V) Maintains a reasonable supply of parts, adequate physical facilities, and qualified service or repair technicians to provide ~~clients~~ MEMBERS with prompt service and repair of all complex rehabilitation technology it sells or supplies; and

(VI) Provides the ~~client~~ MEMBER written information at the time of sale as to how to access service and repair.

(3) The state department shall provide a separate recognition

within the state's medicaid program established ~~under articles 4, 5, and 6 of this title~~ PURSUANT TO THIS ARTICLE 5 AND ARTICLES 4 AND 6 OF THIS TITLE 25.5 for complex rehabilitation technology and shall make other required changes to protect ~~client~~ MEMBER access to appropriate products and services. ~~Such~~ THE separate recognition must take into consideration the customized nature of complex rehabilitation technology and the broad range of related services necessary to meet the unique medical and functional needs of ~~clients~~ MEMBERS and include the following:

(a) The state department notifying the qualified rehabilitation technology suppliers concerning the parameters of the complex rehabilitation technology benefit, which benefit must include the use of qualified rehabilitation technology suppliers as well as billing procedures that specify the types of equipment identified and included in the complex rehabilitation technology benefit. The state department shall create complex rehabilitation technology benefit parameters that are easily understood by and accessible to ~~clients~~ MEMBERS and qualified rehabilitation technology suppliers. The state department shall provide public notice no later than thirty days prior to a collaborative process that includes discussion of any proposed changes to the types of equipment identified and included in the complex rehabilitation technology benefit.

(c) Ensuring that ~~clients~~ MEMBERS receiving complex rehabilitation technology are evaluated or assessed, as needed, by:

(d) Continuing pricing policies for complex rehabilitation technology, unless specifically prohibited by the federal centers for medicare and medicaid services, including the following:

(I) Continuing to ensure that the reimbursement amounts for complex rehabilitation technology, repairs, and supporting clinical

complex rehabilitation technology services are adequate to ensure that ~~qualified clients~~ ELIGIBLE MEMBERS have access to the items, taking into account the unique needs of the ~~clients~~ MEMBERS and the complexity and customization of complex rehabilitation technology. This includes developing pricing policies that ensure access to adequate and timely repairs.

(III) Preserving the option for complex rehabilitation technology to be billed and paid for as a purchase allowing for lump sum payments for devices with a length of need of one year or greater, excluding approved crossover claims for ~~clients~~ MEMBERS enrolled in medicare and medicaid; and

(e) Making other changes as needed to protect access to complex rehabilitation technology for ~~clients~~ MEMBERS.

(5) (a) No later than October 1, 2023, the state board shall promulgate rules establishing repair metrics for all complex rehabilitation technology suppliers and complex rehabilitation technology professionals. At a minimum, the metrics must include requirements for repairing complex rehabilitation technology in a timely manner and the expected quality of each repair. Prior to promulgating rules pursuant to this subsection (5)(a), the state department shall engage in a stakeholder process, which process must include qualified complex rehabilitation technology professionals, qualified complex rehabilitation technology suppliers, and complex rehabilitation technology ~~clients~~ MEMBERS.

(6) Three years after the date the repair metric rules are established pursuant to subsection (5)(a) of this section, the state department may engage in a stakeholder process to determine the need for additional accountability of a qualified complex rehabilitation technology

supplier through financial penalties, audits, or similar tools, for violations of the repair metrics rules. If ~~such~~ a stakeholder process is convened, the process must include qualified complex rehabilitation technology professionals, qualified complex rehabilitation technology suppliers, complex rehabilitation ~~clients~~ MEMBERS, and an advocacy group for persons with disabilities.

(7) Beginning December 1, 2024, the state department shall reimburse labor costs for repairs of complex rehabilitation technology at a rate that is twenty-five percent higher for ~~clients~~ MEMBERS residing in rural areas than the rate for ~~clients~~ MEMBERS residing in urban areas.

SECTION 52. In Colorado Revised Statutes, 25.5-5-326, **amend** (1)(d)(I) as follows:

25.5-5-326. Access to clinical trials - definitions. (1) As used in this section, unless the context otherwise requires:

(d) (I) "Routine costs" means medically necessary items and services that are included under the medical assistance program for a medical assistance ~~recipient~~ MEMBER, to the extent that the provision of ~~such~~ THE items or services to the individual outside the course of such participation would otherwise be covered under the medical assistance program, without regard to whether the ~~recipient~~ MEMBER is enrolled in a clinical trial. For medical assistance ~~recipients~~ MEMBERS participating in an approved clinical trial, "routine costs" include medically necessary items and services that are not otherwise excluded pursuant to subsection (1)(d)(II)(D) of this section, relating to the detection and treatment of complications arising from the medical assistance ~~recipient's~~ MEMBER'S medical care, including complications relating to participation in the clinical trial, to the extent that the provision of ~~such~~ THE items or services

to the individual outside the course of such participation would otherwise be included under the medical assistance program.

SECTION 53. In Colorado Revised Statutes, 25.5-5-327, **amend** (2) as follows:

25.5-5-327. Eligible peer support services - reimbursement - definitions. (2) Subject to available appropriations and to the extent permitted under federal law, the medical assistance program pursuant to this article 5 and articles 4 and 6 of this title 25.5 includes peer support professional services provided to ~~recipients~~ MEMBERS through a recovery support services organization. Peer support professional services must not be provided to ~~recipients~~ MEMBERS until federal approval has been obtained.

SECTION 54. In Colorado Revised Statutes, 25.5-5-333, **amend** (3)(b)(II), (5)(d), and (5)(e) as follows:

25.5-5-333. Primary care and behavioral health statewide integration grant program - creation - report - definition - repeal. (3) (b) Any money received through the grant program must supplement and not supplant existing health-care services. Grant recipients shall not use money received through the grant program for:

(II) Services already covered by medicaid or a ~~client's~~ MEMBER'S OTHER insurance; or

(5) Grant applicants shall demonstrate a commitment to maintaining models and programs that, at a minimum:

(d) Serve publicly funded ~~clients~~ CONSUMERS;

(e) Maintain a plan for how to address a ~~client~~ MEMBER with emergency needs;

SECTION 55. In Colorado Revised Statutes, 25.5-5-335, **amend**

(1), (3), (4) introductory portion, and (4)(a)(II) as follows:

25.5-5-335. Continuous medical coverage for children and adults feasibility study - federal authorization - rules - report - definition. (1) The state department shall study the feasibility of extending continuous medical coverage for additional children and adults and how to better meet the health-related social needs of medical assistance program ~~recipients~~ MEMBERS.

(3) In addition to the study topics detailed in subsection (2) of this section, the feasibility study must study how to best meet the health-related social needs of medical assistance program ~~recipients~~ MEMBERS who are historically disadvantaged and underserved and must give consideration to concerns related to housing and food security.

(4) In conducting the feasibility study pursuant to this section, the state department shall take into consideration the efforts of other states to improve the health-related social needs of medical assistance program ~~recipients~~ MEMBERS, including, but not limited to, housing and nutritional needs, initiatives to pay for rental housing assistance for up to six months, the needs of perinatal ~~recipients~~ MEMBERS, youth in or transitioning out of foster care, former foster care youth, people with substance use disorders, high-risk infants and children, and the needs of low-income individuals impacted by natural disasters, and the state department shall seek input from relevant stakeholders. In conducting the stakeholder process, the state department shall:

(a) Engage directly with:

(II) Service providers, particularly those whose patients are predominantly medical assistance program ~~recipients~~ MEMBERS or are uninsured;

SECTION 56. In Colorado Revised Statutes, 25.5-5-402, **amend** (1), (2)(b), (5), (6)(a), (9)(a), and (12) as follows:

25.5-5-402. Statewide managed care system - rules - definitions - repeal. (1) The state board shall adopt rules to implement a statewide managed care system for Colorado medical assistance ~~recipients~~ MEMBERS pursuant to the provisions of this article 5 and articles 4 and 6 of this title 25.5. The statewide managed care system shall be implemented to the extent possible.

(2) The statewide managed care system implemented pursuant to this article 5 does not include:

(b) Long-term care services and the program of all-inclusive care for the elderly, as described in section 25.5-5-412. For purposes of this subsection (2), "long-term care services" means nursing facilities and home- and community-based services provided to eligible ~~clients~~ MEMBERS who have been determined to be in need of such services pursuant to the "Colorado Medical Assistance Act" and the state board's rules.

(5) The statewide managed care system builds upon the lessons learned from previous managed care and community behavioral health-care programs in the state in order to reduce barriers that may negatively impact medicaid ~~recipient~~ MEMBER experience, medicaid ~~recipient~~ MEMBER health, and efficient use of state resources. The statewide managed care system is authorized to provide services under a single MCE type or a combination of MCE types.

(6) (a) The state department is authorized to assign a medicaid ~~recipient~~ MEMBER to a particular MCE, consistent with federal requirements and rules promulgated by the state board.

(9) **Bidding.** (a) The state department is authorized to institute a program for competitive bidding pursuant to section 24-103-202 or 24-103-203 for MCEs seeking to provide, arrange for, or otherwise be responsible for the provision of services to its ~~enrollees~~ MEMBERS. The state department is authorized to award contracts to more than one offeror. The state department shall use competitive bidding procedures to encourage competition and improve the quality of care available to medicaid ~~recipients~~ MEMBERS over the long term that meets the requirements of this section and section 25.5-5-406.1.

(12) **Graduate medical education.** The state department shall continue the graduate medical education, referred to in this subsection (12) as "GME", funding to teaching hospitals that have graduate medical education expenses in their medicare cost report and are participating as providers under one or more MCEs with a contract with the state department under this part 4. GME funding for ~~recipients~~ MEMBERS enrolled in an MCE is excluded from the premiums paid to the MCE and must be paid directly to the teaching hospital. The state board shall adopt rules to implement this subsection (12) and establish the rate and method of reimbursement.

SECTION 57. In Colorado Revised Statutes, 25.5-5-403, **amend** (2)(b) and (3) as follows:

25.5-5-403. Definitions. As used in this part 4, unless the context otherwise requires:

(2) "Essential community provider", referred to in this part 4 as an "ECP", means a health-care provider that:

(b) Waives charges or charges for services on a sliding scale based on income and does not restrict access or services because of a ~~client's~~

MEMBER'S financial limitations.

(3) (a) "Managed care" means a health-care delivery system organized to manage costs, utilization, and quality. Medicaid managed care provides for the delivery of medicaid health benefits and additional services through contracted arrangements between state medicaid agencies and MCEs.

(b) Nothing in this section ~~shall be deemed to affect~~ AFFECTS the benefits authorized for ~~recipients~~ MEMBERS of the state medical assistance program.

SECTION 58. In Colorado Revised Statutes, 25.5-5-406.1, **amend** (1)(f)(II)(A), (1)(n)(II), (1)(p)(II)(A), (1)(q), (1)(r), and (1)(s)(II) as follows:

25.5-5-406.1. Required features of statewide managed care system. (1) **General features.** All medicaid managed care programs must contain the following general features, in addition to others that the federal government, state department, and state board consider necessary for the effective and cost-efficient operation of those programs:

(f) The MCE shall create, administer, and maintain a network of providers, building on the current network of medicaid providers, to serve the health-care needs of its members. In doing so, the MCE shall:

(II) (A) Seek proposals from each ECP in a county in which the MCE is enrolling ~~recipients~~ MEMBERS for those services that the MCE provides or intends to provide and that an ECP provides or is capable of providing. The MCE shall consider such proposals in good faith and shall, when deemed reasonable by the MCE based on the needs of its ~~enrollees~~ MEMBERS, contract with ECPs. Each ECP shall be willing to negotiate on reasonably equitable terms with each MCE. ECPs making

proposals under this subsection (1)(f)(II) must be able to meet the contractual requirements of the MCE. The requirements of this subsection (1)(f)(II) do not apply to an MCE in areas in which the MCE operates entirely as a group health maintenance organization.

(n) **Grievances and appeals.** (II) The MCE shall have an established grievance system that allows for ~~client~~ MEMBER expression of dissatisfaction at any time about any matter related to the MCE's contracted services, other than an adverse benefit determination. The grievance system must provide timely resolution of ~~such~~ THE matters in a manner consistent with the medical needs of the individual ~~recipient~~ MEMBER.

(p) (II) Prepaid inpatient health plans shall not retroactively recover provider payments if:

(A) A ~~recipient~~ MEMBER was initially determined to be eligible for medical benefits pursuant to section 25.5-4-205 when the provider has an eligibility guarantee number for the ~~recipient~~ MEMBER; or

(q) **Billing medicaid members.** Notwithstanding any federal regulations or the general prohibition of section 25.5-4-301 against providers billing medicaid ~~recipients~~ MEMBERS, a provider may bill a medicaid ~~recipient~~ MEMBER who is enrolled with a specific medicaid PCCM or MCE and, in circumstances defined by the rules of the state board, receives care from a medical provider outside that organization's network or without referral by the ~~recipient's~~ MEMBER'S PCCM;

(r) **Marketing.** In marketing coverage to medicaid ~~recipients~~ MEMBERS, all MCEs shall comply with all applicable provisions of title 10 regarding health plan marketing. The state board is authorized to promulgate rules concerning the permissible marketing of medicaid

managed care. The purposes of ~~such~~ THE rules must include but not be limited to the avoidance of biased selection among the choices available to medicaid ~~recipients~~ MEMBERS.

(s) **Prescription drugs.** All MCEs that have prescription drugs as a covered benefit shall provide prescription drug coverage in accordance with the provisions of section 25.5-5-202 (1)(a) as part of a comprehensive health benefit and with respect to any formulary or other access restrictions:

(II) The MCE shall provide to all medicaid ~~recipients~~ MEMBERS at periodic intervals, and prior to and during enrollment upon request, clear and concise information about the prescription drug program in language understandable to the medicaid ~~recipients~~ MEMBERS, including information about such formulary or other access restrictions and procedures for gaining access to prescription drugs, including off-formulary products; and

SECTION 59. In Colorado Revised Statutes, 25.5-5-408, **amend** (1)(d) and (1)(e) as follows:

25.5-5-408. Capitation payments - availability of base data - adjustments - rate calculation - capitation payment proposal - preference - assignment of medicaid members - definition. (1) (d) The state department shall reimburse a federally qualified health center, as defined in the federal "Social Security Act", 42 U.S.C. sec. 1395x (aa)(4), for the total reasonable costs incurred by the center in providing health-care services to all ~~recipients~~ MEMBERS of medical assistance.

(e) An MCE shall certify, as a condition of entering into a contract with the state department, that the capitation payments set forth in the contract between the MCE and the state department are sufficient to

ensure the financial stability of the MCE with respect to delivery of services to the medicaid ~~recipients~~ MEMBERS covered in the contract.

SECTION 60. In Colorado Revised Statutes, 25.5-5-410, **amend** (2) and (3) as follows:

25.5-5-410. Data collection for managed care programs. (2) The state department of human services, in conjunction with the state department, shall continue its existing efforts, which include obtaining and considering ~~consumer~~ MEMBER input, to develop managed care systems for the developmentally disabled population and to consider a pilot program for a certificate system to enable the developmentally disabled population to purchase managed care services or fee-for-service care, including long-term care community services. The department of human services shall not implement any managed care system for developmentally disabled services without the express approval of the joint budget committee. Any proposed implementation of fully capitated managed care in the developmental disabilities community service system ~~shall require~~ REQUIRES legislative review.

(3) In addition to any other data collection and reporting requirements, each managed care organization shall submit the following types of data to the state department or its agent:

(a) Medical access;

(b) ~~Consumer~~ MEMBER outcomes based on statistics maintained on individual ~~consumers~~ MEMBERS as well as the total ~~consumer~~ MEMBER populations served;

(c) ~~Consumer~~ MEMBER satisfaction;

(d) ~~Consumer~~ MEMBER utilization;

(e) Health status of ~~consumers~~ MEMBERS; and

(f) Uncompensated care delivered.

SECTION 61. In Colorado Revised Statutes, 25.5-5-412, **amend** (6)(b); and **amend as it will become effective July 1, 2024,** (6)(a) as follows:

25.5-5-412. Program of all-inclusive care for the elderly - services - eligibility - rules - legislative declaration - definitions. (6) The state department, in cooperation with the case management agencies established in section 25.5-6-1703, shall develop and implement a coordinated plan to provide education about PACE program site operations under this section. The state board shall adopt rules:

(a) To ensure that case managers and any other appropriate state department staff discuss the option and potential benefits of participating in the PACE program with all eligible long-term care ~~clients~~ MEMBERS. These rules must require additional and on-going training of the case management agency case managers in counties where a PACE program is operating. This training must be provided by a federally approved PACE provider. In addition, each case management agency may designate case managers who have knowledge about the PACE program.

(b) To allow PACE providers to contract with an enrollment broker to include the PACE program in its marketing materials to eligible long-term ~~clients~~ MEMBERS.

SECTION 62. In Colorado Revised Statutes, 25.5-5-415, **amend** (2)(a), (2)(b)(II), (2)(c)(II)(A), (2)(c)(II)(D), and (3) as follows:

25.5-5-415. Medicaid payment reform and innovation pilot program - creation - selection of payment projects - report - rules - legislative declaration. (2) (a) There is ~~hereby~~ created the medicaid payment reform and innovation pilot program for purposes of fostering the

use of innovative payment methodologies in the medicaid program that are designed to provide greater value while ensuring good health outcomes and ~~client~~ MEMBER satisfaction.

(b) (II) The design of the payment project or projects must address the ~~client~~ MEMBER population of the state department's statewide managed care system and be tailored to the region's health-care needs and the resources of the state department's statewide managed care system.

(c) (II) For purposes of selecting payment projects for the pilot program, the state department shall consider, at a minimum:

(A) The likely effect of the payment project on quality measures, health outcomes, and ~~client~~ MEMBER satisfaction;

(D) The ~~client~~ MEMBER population served by the state department's statewide managed care system and the particular health needs of the region;

(3) Pilot program participants shall provide data and information to the state department and any designated evaluator concerning health outcomes, cost, provider participation and satisfaction, ~~client~~ MEMBER satisfaction, and any other data and information necessary to evaluate the efficacy of the payment methodology.

SECTION 63. In Colorado Revised Statutes, 25.5-5-419, **amend** (1)(a), (1)(c), (1)(d), (3)(a), (3)(f), and (3)(i)(III) as follows:

25.5-5-419. Accountable care collaborative - reporting - rules. (1) In 2011, the state department created the accountable care collaborative, also referred to in this title 25.5 as the medicaid coordinated care system. The state department shall continue to provide care delivery through the accountable care collaborative. The goals of the accountable care collaborative are to improve member health and reduce costs in the

medicaid program. To achieve these goals, the state department's implementation of the accountable care collaborative must include, but need not be limited to:

(a) Establishing primary care medical homes for medicaid ~~clients~~ MEMBERS within the accountable care collaborative;

(c) Providing data to regional entities and providers to help manage ~~client~~ MEMBER care;

(d) Integrating the delivery of behavioral health, including mental health and substance use disorders, and physical health services for ~~clients~~ MEMBERS;

(3) On or before December 1, 2017, and on or before December 1 each year thereafter, the state department shall prepare and submit a report to the joint budget committee, the public health care and human services committee of the house of representatives, and the health and human services committee of the senate, or any successor committees, concerning the implementation of the accountable care collaborative. Notwithstanding the provisions of section 24-1-136 (11)(a)(I), the report required pursuant to this subsection (3) continues indefinitely. At a minimum, the state department's report must include the following information concerning the accountable care collaborative:

(a) The number of medicaid ~~clients~~ MEMBERS enrolled in the program;

(f) A description of the state department's coordination with entities that authorize long-term care services for medicaid ~~clients~~ MEMBERS;

(i) Information concerning efforts to reduce medicaid waste and inefficiencies through the accountable care collaborative, including:

(III) Any other efforts by regional entities or the state department to ensure that those who provide care for medicaid ~~clients~~ MEMBERS are aware of and actively participate in reducing waste within the medicaid system.

SECTION 64. In Colorado Revised Statutes, **amend** 25.5-5-503 as follows:

25.5-5-503. Prescription drug benefits - authorization - dual-eligible participation. (1) The state department is authorized to ensure the participation of Colorado medical assistance ~~recipients~~ MEMBERS, who are also eligible for medicare, in any federal prescription drug benefit enacted for medicare recipients.

(2) Prescribed drugs ~~shall not be~~ ARE NOT a covered benefit under the medical assistance program for a ~~recipient~~ MEMBER who is eligible for a prescription drug benefit program under medicare; except that, if a prescribed drug is not a covered Part D drug as defined in the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003", Pub.L. 108-173, the prescribed drug may be a covered benefit if it is otherwise covered under the medical assistance program and federal financial participation is available.

SECTION 65. In Colorado Revised Statutes, **amend** 25.5-5-504 as follows:

25.5-5-504. Providers of pharmaceutical services. (1) Consistent with the provisions of section 25.5-4-401 (1) and ~~consistent with~~ subsections (2) and (3) of this section, and subject to available appropriations, no provider of pharmaceutical services who meets the conditions imposed by this ~~article~~ ARTICLE 5 and articles 4 and 6 of this ~~title~~ TITLE 25.5 and who complies with the terms and conditions

established by the state department and contracting health maintenance organizations and prepaid health plans shall be excluded from contracting for the provision of pharmaceutical services to ~~recipients~~ MEMBERS authorized in this ~~article~~ ARTICLE 5 and articles 4 and 6 of this ~~title~~ TITLE 25.5.

(2) This provision ~~shall~~ DOES not apply to a health maintenance organization or prepaid health plan that enrolls less than forty percent of all the resident medicaid ~~recipients~~ MEMBERS in any county with over one thousand medicaid ~~recipients~~ MEMBERS.

(3) The state board shall establish specifications in rules in order to provide criteria to health maintenance organizations and prepaid health plans which ensure the accessibility and quality of service to ~~clients~~ MEMBERS and the terms and conditions for pharmaceutical contracts.

SECTION 66. In Colorado Revised Statutes, 25.5-5-505, **amend** (1)(a)(II), (1)(b), and (1.5) as follows:

25.5-5-505. Prescribed drugs - mail order - rules. (1) (a) (II) The state board rules must include the definition of maintenance medications. The rules may allow a medical assistance ~~recipient~~ MEMBER to receive through the mail up to a three-month supply, or the maximum allowed under federal law, of maintenance medications used to treat chronic medical conditions.

(b) To the extent allowed by federal law, the state department shall require that a medical assistance ~~recipient~~ MEMBER receiving prescription medication through the mail pay the same copayment amount as a medical assistance ~~recipient~~ MEMBER receiving prescription medication through any other method. The state department shall encourage medical assistance ~~recipients~~ MEMBERS who choose to receive maintenance

medications through the mail to use local retail pharmacies for mail delivery.

(1.5) The state department shall publish on its website and include in the ~~recipient~~ MEMBER handbook the following information for ~~recipients~~ MEMBERS enrolled in fee-for-service medical assistance programs:

(a) That a medical assistance ~~recipient~~ MEMBER may use the pharmacy of ~~his or her~~ THE MEMBER'S choice;

(b) That a medical assistance ~~recipient~~ MEMBER may use a local retail pharmacy for mail delivery of maintenance medications, if offered; and

(c) That the copayment amount for prescription medications is the same at any pharmacy enrolled in the medical assistance program.

SECTION 67. In Colorado Revised Statutes, 25.5-5-509, **amend** (2)(b) as follows:

25.5-5-509. Substance use disorder - prescription drugs - opiate antagonist. (2) (b) A hospital or emergency department shall receive reimbursement under the medical assistance program for the cost of an opiate antagonist if, in accordance with section 12-30-110, a prescriber, as defined in section 12-30-110 (7)(h), dispenses an opiate antagonist upon discharge to a medical assistance ~~recipient~~ MEMBER who is at risk of experiencing an opiate-related drug overdose event or to a family member, friend, or other person in a position to assist a medical assistance ~~recipient~~ MEMBER who is at risk of experiencing an opiate-related drug overdose event.

SECTION 68. In Colorado Revised Statutes, 25.5-5-514, **amend** (2)(a) as follows:

25.5-5-514. Prescription drugs used for treatment or prevention of HIV - prohibition on utilization management - definition. (2) (a) Before July 1, 2027, the state department shall not restrict by prior authorization or step therapy requirements any prescription drug approved by the federal food and drug administration that is used for the treatment or prevention of HIV if a prescribing practitioner licensed pursuant to title 12 has determined the prescription drug to be medically necessary for the treatment or prevention of HIV for a ~~recipient~~ MEMBER. Prescription drugs used for the treatment or prevention of HIV include protease inhibitors, non-nucleoside reverse transcriptase inhibitors, nucleoside reverse transcriptase inhibitors, antivirals, integrase inhibitors, long-acting medications, and fusion inhibitors.

SECTION 69. In Colorado Revised Statutes, 25.5-6-102, **amend** (1) introductory portion and (1)(d) as follows:

25.5-6-102. Court-approved trusts - transfer of property for persons seeking medical assistance for nursing home care - undue hardship - legislative declaration. (1) The general assembly ~~hereby~~ finds, determines, and declares that:

(d) It is therefore appropriate to enact state laws which limit ~~such~~ court-approved trusts in a manner that is consistent with Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396 et seq., as amended, and which provide that persons who qualify for assistance as a result of the creation of such trusts ~~shall be~~ ARE treated the same as any other ~~recipient~~ MEMBER of medical assistance for nursing home care;

SECTION 70. In Colorado Revised Statutes, 25.5-6-104, **amend** (1)(b), (1)(c), (2)(b), (2)(d), (2)(e), (2)(f), (2)(i), (2)(j), (2)(k), (3)(a), (3)(b)

introductory portion, (3)(b)(VII), (3)(c), (3)(d) introductory portion, (3)(d)(I) introductory portion, (3)(d)(II), (3)(d)(III), (3)(d)(V), (3)(e), and (5)(a) as follows:

25.5-6-104. Long-term care placements - comprehensive and uniform assessment instrument - report - legislative declaration - definitions - repeal. (1) (b) The general assembly further finds, determines, and declares that the state is in need of a long-term care system that organizes each long-term care ~~client's~~ APPLICANT'S AND MEMBER'S entry, assessment of need, and service delivery into a single unified system, and that ~~such~~ THE system must include, at a minimum, a locally established single entry point administered by a designated entity, a single ~~client~~ assessment instrument and administrative process, targeted case management in order to maximize existing federal, state, and local funding, case management, and an accountability mechanism designed to assure that budget allocations are being effectively managed.

(c) The general assembly therefore concludes that it is appropriate to develop and implement a comprehensive and uniform long-term care ~~client~~ assessment process and to study the establishment of a single entry point system that provides for the coordination of access and service delivery to long-term care ~~clients~~ MEMBERS at the local level, that is available to all ~~persons~~ INDIVIDUALS in need of long-term care, and that is well managed and cost-efficient.

(2) As used in this section and in sections 25.5-6-105 to 25.5-6-107, unless the context otherwise requires:

(b) "Case management services" means the assessment of ~~a~~ AN INDIVIDUAL'S NEED FOR long-term care, ~~client's needs,~~ the development and implementation of a care plan for ~~such client~~ THE MEMBER, the

coordination and monitoring of long-term care service delivery, the direct delivery of services as provided by this ~~article~~ ARTICLE 6 or by rules adopted by the state board pursuant to this ~~article~~ ARTICLE 6, the evaluation of service effectiveness, and the reassessment of ~~such client's~~ THE MEMBER'S needs, all of which shall be performed by a single entry point as defined in ~~paragraph (k) of this subsection (2)~~ SUBSECTION (2)(k) OF THIS SECTION.

(d) "Comprehensive and uniform ~~client~~ assessment process" means a standard procedure, which includes the use of a uniform assessment instrument, to measure a ~~client's~~ MEMBER'S OR APPLICANT'S functional capacity, to determine the social and medical needs of a current or potential ~~client~~ MEMBER OR APPLICANT of any long-term care program, and to target resources to the functionally impaired.

(e) "Continuum of care" means an organized system of long-term care, benefits, and services to which a ~~client~~ MEMBER has access and which enables a ~~client~~ MEMBER to move from one level or type of care to another without encountering gaps in or barriers to service.

(f) "Information and referral" means the provision of specific, accurate, and timely public information about services available to aging and disabled adults in need of long-term care and referral to alternative agencies, programs, and services based on ~~client~~ MEMBER inquiries.

(i) "Resource development" means the study, establishment, and implementation of additional resources or services which will extend the capabilities of community long-term care systems to better serve long-term care ~~clients~~ MEMBERS.

(j) "Screening" means a preliminary determination of need for long-term care services and, on the basis of ~~such~~ THE determination, the

making of an appropriate referral for ~~a client~~ AN assessment in accordance with subsection (3) of this section or referral to another community resource to assist ~~clients~~ INDIVIDUALS who are not in need of long-term care services.

(k) "Single entry point" means the availability of a single access or entry point within a local area where a current or potential long-term care ~~client~~ MEMBER OR APPLICANT can obtain long-term care information, screening, assessment of need, and referral to appropriate long-term care program and case management services.

(3) (a) On or before July 1, 1991, the state department shall establish, by rule in accordance with article 4 of title 24, ~~C.R.S.,~~ a comprehensive and uniform ~~client~~ assessment process for all individuals in need of long-term care, the purpose of which is to determine the appropriate services and levels of care necessary to meet ~~clients'~~ MEMBERS' OR APPLICANTS' needs, to analyze alternative forms of care and the payment sources for ~~such~~ THE care, and to assist in the selection of long-term care programs and services that meet ~~clients'~~ MEMBERS' OR APPLICANTS' needs most cost-efficiently.

(b) Participation in the ASSESSMENT process ~~shall be~~ IS mandatory for ~~clients~~ MEMBERS of publicly funded long-term care programs, including, but not limited to, the following:

(VII) Home health services for long-term care ~~clients~~ MEMBERS; and

(c) Private paying ~~clients~~ MEMBERS of long-term care programs may participate in the process for a fee to be established by the state department and adopted through rules.

(d) The state department, through rules, shall develop and

implement no later than July 1, 1991, a uniform long-term care ~~client~~ needs assessment instrument for all individuals ~~needing~~ IN NEED OF long-term care. The instrument ~~shall~~ MUST be used as part of the comprehensive and uniform ~~client~~ assessment process to be established in accordance with subsection (3)(a) of this section and ~~shall~~ MUST serve the following functions:

(I) To obtain information on each ~~client's~~ MEMBER'S OR APPLICANT'S status in the following areas:

(II) To assess each ~~client's~~ MEMBER'S OR APPLICANT'S physical environment in terms of meeting the ~~client's~~ MEMBER'S OR APPLICANT'S needs;

(III) To obtain information on each ~~client's~~ MEMBER'S OR APPLICANT'S payment sources, including obtaining financial eligibility information for publicly funded long-term care programs;

(V) To prioritize a ~~client's~~ MEMBER'S OR APPLICANT'S need for care using criteria established by the state department for specific publicly funded long-term care programs;

(e) On and after July 1, 1991, ~~no publicly funded client shall~~ A MEMBER MUST NOT be placed in a long-term care program unless ~~such~~ THE placement is in accordance with rules adopted by the state board in implementing this section.

(5) (a) On or before July 1, 2018, pursuant to the state department's ongoing stakeholder process relating to eligibility determination for long-term services and supports pursuant to this ~~article~~ ARTICLE 6, the state department shall select a needs assessment tool for ~~persons~~ INDIVIDUALS receiving long-term services and supports, including ~~persons~~ INDIVIDUALS with intellectual and developmental disabilities who are

eligible for services pursuant to section 25.5-6-409. Once selected, the state department shall begin assessing ~~client~~ THE INDIVIDUAL'S needs using the needs assessment tool as soon as practicable.

SECTION 71. In Colorado Revised Statutes, 25.5-6-105, **amend** (1) introductory portion, (1)(b), and (1)(c) as follows:

25.5-6-105. Legislative declaration relating to implementation of single entry point system - repeal. (1) The general assembly ~~hereby~~ finds, determines, and declares that:

(b) The establishment of a single entry point system for the coordination of access to existing services and service delivery for all long-term care ~~clients~~ MEMBERS at the local level can be implemented in a cost-efficient manner;

(c) The implementation of a well-managed single entry point system will result in the utilization of more appropriate services by long-term care ~~clients~~ MEMBERS over time and will provide better information on the unmet service needs of ~~clients~~ MEMBERS; and

SECTION 72. In Colorado Revised Statutes, 25.5-6-106, **amend** (2)(b) introductory portion, (2)(c) introductory portion, (2)(c)(III), (2)(c)(IV), (2)(c)(V), and (3)(b) as follows:

25.5-6-106. Single entry point system - authorization - phases for implementation - services provided - repeal. (2) **Single entry point agencies - service programs - functions.** (b) The agency may serve private paying ~~clients~~ MEMBERS on a fee-for-service basis and shall serve ~~clients~~ MEMBERS of publicly funded long-term care programs, including, but not limited to, the following:

(c) The major functions of a single entry point ~~shall~~ MUST include, but need not be limited to, the following:

(III) Assessing ~~clients'~~ MEMBERS' needs in accordance with section 25.5-6-104;

(IV) Developing plans of care for ~~clients~~ MEMBERS;

(V) Determining payment sources available to ~~clients~~ MEMBERS for long-term care services;

(3) **State certification of a single entry point agency - quality assurance standards.** (b) The state board shall adopt rules for the establishment of a quality assurance program for the purpose of monitoring the quality of services provided to ~~clients~~ MEMBERS and for recertifying single entry point agencies. The rules shall provide for: Procedures to evaluate the quality of services provided by the agency; an assessment of the agency's compliance with program requirements, including compliance with case management standards, which standards shall be adopted by the state department; an assessment of an agency's performance of administrative functions, including reasonable costs per ~~client~~ MEMBER, timely responses, managing programs in one consolidated unit, on-site visits to ~~clients~~ MEMBERS, community coordination and outreach, and ~~client~~ MEMBER monitoring; a determination as to whether targeted populations are being identified and served; and an evaluation concerning financial accountability.

SECTION 73. In Colorado Revised Statutes, 25.5-6-107, **amend** (1) introductory portion, (1)(c)(II), and (2) as follows:

25.5-6-107. Financing of single entry point system - repeal. (1) The single entry point system shall be financed with the following ~~moneys~~ FUNDING:

(c) County contributions, as follows:

(II) The amount contributed from each county in accordance with

~~subparagraph (I) of this paragraph (c)~~ SUBSECTION (1)(c)(I) OF THIS SECTION after making an adjustment based on the percentage of an increase or decrease per fiscal year in the service costs for ~~clients~~ MEMBERS of ~~such~~ THE county. However, ~~in no case shall~~ a county ~~be~~ IS NOT required under this ~~subparagraph (II)~~ SUBSECTION (1)(c)(II) to contribute more than a five percent increase in ~~said~~ service costs.

(2) County contributions for ~~client~~ MEMBER services made in accordance with ~~subparagraph (I) of paragraph (c) of subsection (1)~~ SUBSECTION (1)(c)(I) of this section ~~shall~~ MUST be expended only for ~~clients~~ MEMBERS of the county providing ~~said~~ THE contribution.

SECTION 74. In Colorado Revised Statutes, 25.5-6-108.5, **amend** (1)(a), (2)(a) introductory portion, (2)(a)(I), and (2)(a)(II) as follows:

25.5-6-108.5. Community long-term care studies - authority to implement - alternative care facility report. (1) (a) Subject to the receipt of sufficient ~~moneys~~ FUNDING pursuant to ~~paragraph (c) of this subsection (1)~~ SUBSECTION (1)(c) OF THIS SECTION, the state department shall contract for one or more studies of the population of ~~recipients~~ MEMBERS receiving services under the home- and community-based waivers authorized pursuant to this ~~article~~ ARTICLE 6. The state department shall make necessary data available to the contractor, including but not limited to data on activities of daily living. In selecting a contractor to perform any study conducted pursuant to this subsection (1), the state department is not required to follow the competitive bidding requirements of the "Procurement Code", articles 101 to 112 of title 24. ~~C.R.S.~~ The state department shall provide copies of all studies conducted pursuant to this subsection (1) to members of the health and human services committees

of the general assembly, or any successor committees, and to the members of the joint budget committee.

(2) (a) Subject to the receipt of sufficient ~~moneys~~ FUNDING, one of the studies contracted for pursuant to subsection (1) of this section ~~shall~~ MUST include research and analysis of:

(I) The number of ~~recipients~~ MEMBERS with incontinence, Alzheimer's disease, dementia, or other diagnoses of a chronic incapacitating condition that severely limit ~~their~~ THE MEMBER'S activities of daily living who would benefit from receiving additional services through an alternative care facility ~~thereby avoiding~~ TO AVOID nursing home placement;

(II) The actuarially sound rate for providing services for the ~~recipients~~ MEMBERS at an alternative care facility;

SECTION 75. In Colorado Revised Statutes, 25.5-6-113, **amend** (1)(a) introductory portion, (1)(a)(VIII), (1)(b), and (5) as follows:

25.5-6-113. Health home - integrated services - contracting - legislative declaration - definitions. (1) (a) The general assembly ~~hereby~~ finds and declares that:

(VIII) The system must ensure a comprehensive approach to long-term care that addresses the different demographic and geographic challenges in the state and the various long-term care services and supports that ~~clients~~ MEMBERS need.

(b) Therefore, the general assembly declares that a comprehensive approach to long-term care requires that programs and policies integrating and coordinating care under the medicaid program be flexible and allow for full participation by providers of long-term care services to ensure quality of care for ~~clients~~ MEMBERS and efficient use of limited resources.

(5) Dually eligible ~~clients~~ MEMBERS may voluntarily elect to participate in a recognized medicare coordinated care system and may voluntarily elect to participate in the state department's medicaid coordinated care system.

SECTION 76. In Colorado Revised Statutes, 25.5-6-116, **amend** (1) as follows:

25.5-6-116. Community placement transformation - creation - report - repeal. (1) The state department shall undertake efforts to transform the state department's process for ~~clients~~ MEMBERS OR APPLICANTS attempting to receive long-term care in the community.

SECTION 77. In Colorado Revised Statutes, 25.5-6-206, **amend** (1), (2), and (6) as follows:

25.5-6-206. Personal needs benefits - amount - patient personal needs trust fund required - funeral and final disposition expenses - penalty for illegal retention and use. (1) The state department, pursuant to its rules, may include in medical care benefits provided under this article 6 and articles 4 and 5 of this title 25.5 reasonable amounts for the personal needs of any ~~recipient~~ MEMBER receiving nursing facility services or intermediate care facilities for individuals with intellectual disabilities, if the ~~recipient~~ MEMBER is not otherwise eligible for the amounts from other categories of public assistance, but the amounts for personal needs must not be less than the minimum amount provided for in subsection (2) of this section. Payments for funeral and final disposition expenses upon the death of a ~~recipient~~ MEMBER may be provided under rules of the state department in the same manner as provided to ~~recipients~~ MEMBERS of public assistance as defined by section 26-2-103 (8).

(2) (a) The basic minimum amount payable pursuant to subsection

(1) of this section for personal needs to any ~~recipient~~ MEMBER admitted to a nursing facility or intermediate care facility for individuals with intellectual disabilities is seventy-five dollars monthly; except that, commencing January 1, 2015, and each January 1 thereafter, the basic minimum amount ~~shall~~ MUST increase annually by the same percentage applied to the general fund share of the aggregate statewide average of the per diem net of patient payment pursuant to section 25.5-6-202 (9)(b)(I). Commencing with the fiscal year beginning July 1, 2014, and each fiscal year thereafter, the reduction to patient payments received by nursing facilities resulting from an increase in the basic minimum amount ~~shall be~~ IS funded in full by general fund and applicable federal funds.

(b) On and after October 1, 1992, the basic minimum amount payable pursuant to subsection (1) of this section for personal needs ~~shall be~~ IS ninety dollars for the following persons:

(I) A medical assistance ~~recipient~~ MEMBER who receives a non-service connected disability pension from the United States veterans administration, has no spouse or dependent child, and is admitted to or is residing in a nursing facility; and

(II) A medical assistance ~~recipient~~ MEMBER who is a surviving spouse of a person who received a non-service connected disability pension from the United States veterans administration, has no dependent child, and is admitted to or is residing in a nursing facility.

(6) Any overpayment of personal needs funds to a nursing facility or an intermediate care facility for individuals with intellectual disabilities by the state department due to the omission, error, fraud, or defalcation of the nursing facility or intermediate care facility for individuals with intellectual disabilities or any shortage in an audited patient personal

needs trust fund ~~shall be~~ IS recoverable by the state on behalf of the ~~recipient~~ MEMBER in the same manner and following the same procedures as specified in section 25.5-4-301 (2) for an overpayment to a provider.

SECTION 78. In Colorado Revised Statutes, 25.5-6-209, **amend** (1) as follows:

25.5-6-209. Establishment of nursing facility provider demonstration of need - criteria - rules. (1) The state department, in making any medicaid certification determination, shall encourage an appropriate allocation of public health-care resources and the development of alternative or substitute methods of delivering health-care services so that adequate long-term care services are made reasonably available to every qualified ~~recipient~~ MEMBER within the state at the appropriate level of care, at the lowest reasonable aggregate cost, and in the least restrictive setting. Medicaid certification determinations shall be made in accordance with *Olmstead v. L.C.*, 527 U.S. 581 (1999).

SECTION 79. In Colorado Revised Statutes, 25.5-6-303, **amend** (20); and **amend as it will become effective July 1, 2024,** (7) as follows:

25.5-6-303. Definitions - repeal. As used in this part 3, unless the context otherwise requires:

(7) "Case plan" means a coordinated plan for the provision of long-term-care services in a setting other than a nursing home, developed and managed by a case management agency, in coordination with the ~~client~~ MEMBER, the ~~client's~~ MEMBER'S family or guardian, the ~~client's~~ MEMBER'S physician, and other providers of care.

(20) "Respite care services" means services of a short-term nature provided to a ~~client~~ MEMBER, in the home or in a facility approved by the state department, in order to temporarily relieve the family or other home

providers from the care and maintenance of ~~such client~~ THE MEMBER, including room and board, maintenance, personal care, and other related services.

SECTION 80. In Colorado Revised Statutes, 25.5-6-307, **amend** (5)(a)(III) and (5)(e)(I) as follows:

25.5-6-307. Services for the elderly, blind, and disabled. (5) (a) No later than January 2024, the state department shall submit a report to the senate health and human services committee, the house of representatives public and behavioral health and human services committee, and the house of representatives health and insurance committee, or any successor committees, as part of its "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act" presentation required by section 2-7-203. At a minimum, the report must identify:

(III) A system of common reporting to ensure a ~~recipient~~ MEMBER does not exceed the medicaid benefit in a multi-provider scenario; and

(e) (I) The state department shall promulgate any necessary rules to ensure transportation network companies comply with federal and state oversight requirements and shall include all relevant stakeholders, including medicaid ~~recipients~~ MEMBERS, transportation network companies, current providers and drivers for nonmedical transportation services, and other PARTIES interested ~~parties~~ in ~~the development of such~~ DEVELOPING THE requirements.

SECTION 81. In Colorado Revised Statutes, 25.5-6-310, **amend** (2) as follows:

25.5-6-310. Special provisions - personal care services provided by a family - repeal. (2) The maximum reimbursement for the services

provided by a member of the person's family per year for each ~~client shall~~ MEDICAID MEMBER MUST not exceed the equivalent of four hundred forty-four service units per year for a member of the eligible person's family.

SECTION 82. In Colorado Revised Statutes, 25.5-6-314, **amend** (1)(c) as follows:

25.5-6-314. Training for staff providing direct-care services to members with dementia - rules - definitions. (1) As used in this section:

(c) "Direct-care staff member" means a staff member caring for the physical, emotional, or mental health needs of ~~clients~~ MEMBERS of an adult day care facility and whose work involves regular contact with ~~clients~~ MEMBERS who are living with dementia diseases and related disabilities.

SECTION 83. In Colorado Revised Statutes, 25.5-6-404, **amend** (4) as follows:

25.5-6-404. Duties of the department of health care policy and financing and the department of human services. (4) The executive director and the state board shall promulgate ~~such~~ rules regarding this part 4 as ~~are~~ necessary to fulfill the obligations of the state department as the single state agency to administer medical assistance programs in accordance with Title XIX of the federal "Social Security Act", as amended. ~~Such~~ THE rules may include, but ~~shall~~ ARE not ~~be~~ limited to, determination of the level of care requirements for long-term care, patient payment requirements, ~~clients'~~ MEMBERS' rights, medicaid eligibility, and appeal rights associated with these requirements.

SECTION 84. In Colorado Revised Statutes, 25.5-6-409, **amend**

(5)(a)(III) and (5)(e)(I) as follows:

25.5-6-409. Services for persons with intellectual and developmental disabilities. (5) (a) No later than January 2024, the state department shall submit a report to the senate health and human services committee, the house of representatives public and behavioral health and human services committee, and the house of representatives health and insurance committee, or any successor committees, as part of its "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act" presentation required by section 2-7-203. At a minimum, the report must identify:

(III) A system of common reporting to ensure a ~~recipient~~ MEMBER does not exceed the medicaid benefit in a multi-provider scenario; and

(e) (I) The state department shall promulgate any necessary rules to ensure transportation network companies comply with federal and state oversight requirements and shall include all relevant stakeholders, including medicaid ~~recipients~~ MEMBERS, transportation network companies, current providers and drivers for nonmedical transportation services, and other PARTIES interested ~~parties~~ in ~~the development of such~~ DEVELOPING THE requirements.

SECTION 85. In Colorado Revised Statutes, 25.5-6-409.3, **amend** (3.3)(a) introductory portion, (3.3)(a)(I), and (3.3)(a)(III) as follows:

25.5-6-409.3. Consolidated waiver - intellectual and developmental disabilities - conflict-free case management - legislative declaration - repeal. (3.3) (a) The state department's administration of the redesigned waiver ~~shall~~ MUST include:

(I) A functional eligibility and needs assessment tool used for the

redesigned waiver that aligns with the recommendations of the community living advisory group and that is fully integrated with the assessment process for all ~~clients~~ MEMBERS receiving long-term services and supports;

(III) A service payment system that ensures fair distribution of available resources and that is efficient, transparent, and equitable for both providers and ~~consumers~~ MEMBERS.

SECTION 86. In Colorado Revised Statutes, **amend** 25.5-6-411 as follows:

25.5-6-411. Personal needs trust fund required. All personal needs funds ~~shall~~ MUST be held in trust by a residential facility authorized to provide services pursuant to this part 4, or ~~its~~ THE RESIDENTIAL FACILITY'S designated trustee, separate and apart from any other funds of the facility, in a checking account or savings account or any combination ~~thereof~~ established to protect and separate the personal needs funds of the ~~clients~~ MEMBERS. At all times, the principal and all income derived from ~~said~~ THE principal in the personal needs trust fund ~~shall~~ MUST remain the property of the participating ~~clients~~ MEMBERS, and the RESIDENTIAL facility or ~~its~~ THE FACILITY'S designated trustee is bound by all of the duties imposed by law upon fiduciaries in ~~the~~ handling ~~of such~~ THE fund including accounting for all expenditures from the fund.

SECTION 87. In Colorado Revised Statutes, 25.5-6-606, **amend** (8)(a)(III) and (8)(e)(I) as follows:

25.5-6-606. Implementation of program for persons with mental health disorders authorized - federal waiver - duties of the department of health care policy and financing and the department of human services - rules. (8) (a) No later than January 2024, the state department shall submit a report to the senate health and human services

committee, the house of representatives public and behavioral health and human services committee, and the house of representatives health and insurance committee, or any successor committees, as part of its "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act" presentation required by section 2-7-203. At a minimum, the report must identify:

(III) A system of common reporting to ensure a ~~recipient~~ MEMBER does not exceed the medicaid benefit in a multi-provider scenario; and

(e) (I) The state department shall promulgate any necessary rules to ensure transportation network companies comply with federal and state oversight requirements and shall include all relevant stakeholders, including medicaid ~~recipients~~ MEMBERS, transportation network companies, current providers and drivers for nonmedical transportation services, and other PARTIES interested ~~parties~~ in ~~the development of such~~ DEVELOPING THE requirements.

SECTION 88. In Colorado Revised Statutes, 25.5-6-703, **amend** (1), (2), (6)(a), (7), and (10) as follows:

25.5-6-703. Definitions - repeal. As used in this part 7, unless the context otherwise requires:

(1) "Adult day care" means health and social services furnished two or more hours per day on a regularly scheduled basis for one or more days per week in an outpatient setting and for the purpose of ensuring the optimal functioning of the ~~recipient~~ MEMBER.

(2) "Behavioral programming" means an individualized plan that sets forth strategies to decrease a ~~recipient's~~ MEMBER'S maladaptive behaviors that interfere with the ~~recipient's~~ MEMBER'S ability to remain in the community. Behavioral programming includes a complete assessment

of maladaptive behaviors of the ~~recipient~~ MEMBER, the development and implementation of a structured behavioral intervention plan, continuous training and supervision of caregivers and behavioral aides, and periodic reassessment of the individualized plan.

(6) (a) "Personal care services" means assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. Personal care services include assistance with the preparation of meals, but not the cost of the meals, and homemaker services that are necessary for the health and safety of the ~~recipient~~ MEMBER.

(7) "Structured day treatment" means structured, nonresidential therapeutic treatment services that are directed at the development and maintenance of community living skills and are provided two or more hours per day on a regularly scheduled basis for one or more days per week. Day treatment services include supervision and specific training that allows a ~~recipient~~ MEMBER to function at the ~~recipient's~~ MEMBER'S maximum potential. The services include, but are not limited to, social skills training that allows for reintegration into the community, sensory and motor development services, and services aimed at reducing maladaptive behavior.

(10) "Transitional living" means a nonmedical residential program that provides training and twenty-four-hour supervision to a ~~recipient~~ MEMBER that will enhance the ~~recipient's~~ MEMBER'S ability to live more independently.

SECTION 89. In Colorado Revised Statutes, 25.5-6-704, **amend** (7)(a)(III) and (7)(e)(I) as follows:

25.5-6-704. Implementation of home- and community-based services program for persons with brain injury authorized - federal

waiver - duties of the department - rules - repeal. (7) (a) No later than January 2024, the state department shall submit a report to the senate health and human services committee, the house of representatives public and behavioral health and human services committee, and the house of representatives health and insurance committee, or any successor committees, as part of its "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act" presentation required by section 2-7-203. At a minimum, the report must identify:

(III) A system of common reporting to ensure a ~~recipient~~ MEMBER does not exceed the medicaid benefit in a multi-provider scenario; and

(e) (I) The state department shall promulgate any necessary rules to ensure transportation network companies comply with federal and state oversight requirements and shall include all relevant stakeholders, including medicaid ~~recipients~~ MEMBERS, transportation network companies, current providers and drivers for nonmedical transportation services, and other PARTIES interested ~~parties~~ in ~~the development of such~~ DEVELOPING THE requirements.

SECTION 90. In Colorado Revised Statutes, 25.5-6-903, **amend** (1) as follows:

25.5-6-903. Residential child health-care program - waiver - home- and community-based services - rules. (1) Subject to federal authorization, the state department shall implement a program for medicaid-eligible children with intellectual and developmental disabilities, as defined in section 25.5-10-202, with significant behavioral support needs who are at risk of institutionalization. The state board shall establish, by rule, the type of services provided pursuant to the program, to the extent the services are cost-efficient, and the ~~recipient~~ MEMBER

eligibility criteria that may include, but are not limited to, a medical necessity determination and a financial eligibility determination.

SECTION 91. In Colorado Revised Statutes, **amend** 25.5-6-1201 as follows:

25.5-6-1201. Legislative declaration - repeal. (1) The general assembly finds that there may be a more effective way to deliver home- and community-based services to the elderly, blind, and disabled; to disabled children; and to persons with spinal cord injuries, that allows for more self-direction in their care and a cost savings to the state. The general assembly also finds that every person that is currently receiving home- and community-based services does not need the same level of supervision and care from a licensed health-care professional in order to meet ~~his or her~~ THE PERSON'S care needs and remain living in the community. The general assembly, therefore, declares that it is beneficial to the elderly, blind, and disabled ~~clients~~ MEMBERS of home- and community-based services, to ~~clients~~ MEMBERS of the disabled children care program, and to ~~clients~~ MEMBERS enrolled in the spinal cord injury waiver pilot program, for the state department to develop a service that would allow ~~these people~~ THE MEMBERS to receive in-home support.

(2) The general assembly further finds that allowing ~~clients~~ MEMBERS more self-direction in ~~their~~ THE MEMBERS' care is a more effective way to deliver home- and community-based services to ~~clients~~ MEMBERS with major mental health disorders and brain injuries, as well as to ~~clients~~ MEMBERS receiving home- and community-based supportive living services and children's extensive support services. Therefore, the general assembly declares that it is appropriate for the state department to develop a plan for expanding the availability of in-home support services

to include these ~~clients~~ MEMBERS.

(3) This section is repealed, effective July 1, 2025.

SECTION 92. In Colorado Revised Statutes, 25.5-6-1203, **amend** (4); and **amend as it will become effective July 1, 2024,** (5) as follows:

25.5-6-1203. In-home support services - eligibility - licensure exclusion - in-home support service agency responsibilities - rules - repeal. (4) (a) In-home support service agencies providing in-home support services shall provide twenty-four-hour back-up services to ~~their clients~~ THE AGENCIES' MEMBERS. In-home support service agencies shall either contract with or have on staff a state licensed health-care professional, as defined by ~~the~~ state board by rule, acting within the scope of the person's profession. The state board shall promulgate rules setting forth the training requirements for attendants providing in-home support services and the oversight and monitoring responsibilities of the state licensed health-care professional that is either contracting with or is on staff with the in-home support service agency. The state board rules must allow the eligible person or the eligible person's authorized representative, parent of a minor, or guardian to determine, in conjunction with the in-home support services agency, the amount of oversight needed in connection with the eligible person's in-home support services.

(b) The state board shall promulgate rules that establish how an in-home support service agency can discontinue a ~~client~~ MEMBER under this part 12. The rules ~~shall~~ MUST establish that a ~~client~~ MEMBER can only be involuntarily discontinued when equivalent care in the community has been secured or that a ~~client~~ MEMBER can be discontinued after exhibiting documented prohibited behavior involving attendants, including abuse of attendants, and that dispute resolution has failed. The ~~determination of~~

STATE DEPARTMENT SHALL DETERMINE whether an in-home support service agency has made adequate attempts at resolution. ~~shall be made by the state department.~~

(5) The case management agencies established in section 25.5-6-1703 ~~shall be~~ ARE responsible for determining a person's eligibility for in-home support services; except that for eligible disabled children the state department shall designate the entity that will determine the child's eligibility. The state board shall promulgate rules specifying the case management agencies' responsibilities pursuant to this part 12. At a minimum, ~~these~~ THE rules must require that case managers discuss the option and potential benefits of in-home support services with all eligible long-term care ~~clients~~ MEMBERS.

SECTION 93. In Colorado Revised Statutes, 25.5-6-1303, **amend** (5)(c), (8)(a)(III), and (8)(e)(I) as follows:

25.5-6-1303. Pilot program - complementary or alternative medicine - rules. (5) The state department shall cause to be conducted an independent evaluation of the pilot program to be completed no later than January 1, 2025. The state department shall provide a report of the evaluation to the health and human services committee of the senate and the public health care and human services committee of the house of representatives, or any successor committees. The report on the evaluation must include the following:

(c) Feedback from ~~consumers~~ MEMBERS and the state department concerning the progress and success of the pilot program;

(8) (a) No later than January 2024, the state department shall submit a report to the senate health and human services committee, the house of representatives public and behavioral health and human services

committee, and the house of representatives health and insurance committee, or any successor committees, as part of its "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act" presentation required by section 2-7-203. At a minimum, the report must identify:

(III) A system of common reporting to ensure a ~~recipient~~ MEMBER does not exceed the medicaid benefit in a multi-provider scenario; and

(e) (I) The state department shall promulgate any necessary rules to ensure transportation network companies comply with federal and state oversight requirements and shall include all relevant stakeholders, including medicaid ~~recipients~~ MEMBERS, transportation network companies, current providers and drivers for nonmedical transportation services, and other PARTIES interested ~~parties~~ in ~~the development of such~~ DEVELOPING THE requirements.

SECTION 94. In Colorado Revised Statutes, 25.5-6-1402, **amend** (1) and (5) as follows:

25.5-6-1402. Definitions. As used in this part 14, unless the context otherwise requires:

(1) "Basic coverage group" means the category of eligibility under the federal "Ticket to Work and Work Incentives Improvement Act of 1999", Pub.L. 106-170, that provides an opportunity to buy into medicaid consistent with the federal "Social Security Act", 42 U.S.C. sec. 1396a (a)(10)(A)(ii)(XV), as amended, for each worker with disabilities who is at least sixteen years of age but less than sixty-five years of age and who, except for earnings, would be eligible for the supplemental security income program. A person who is eligible under the basic coverage group may also be a home- and community-based services waiver ~~recipient~~

MEMBER.

(5) "Medical improvement group" means the category of eligibility under the federal "Ticket to Work and Work Incentives Improvement Act of 1999", Pub.L. 106-170, that provides an opportunity to buy into medicaid consistent with the federal "Social Security Act", 42 U.S.C. sec. 1496a (a)(10)(A)(ii)(XV), as amended, for each worker with a medically improved disability who is at least sixteen years of age but less than sixty-five years of age and who was previously in the basic coverage group and is no longer eligible for the basic coverage group due to medical improvement. A person who is eligible under the medical improvement group may also be a home- and community-based services waiver ~~recipient~~ MEMBER.

SECTION 95. In Colorado Revised Statutes, 25.5-6-1602, **amend** (1) introductory portion and (2) as follows:

25.5-6-1602. State department to request increase in reimbursement rate for certain services. (1) Not more than ninety days after May 28, 2019, the state department shall request from the federal government an increase of eight and one-tenth percent in the reimbursement rate for the following services delivered to ~~consumers~~ MEMBERS through the home- and community-based services waivers:

(2) For the 2019-20 fiscal year, each home care agency shall pay one hundred percent of the funding that results from the rate increase described in subsection (1) of this section as compensation for employees who provide personal care services, homemaker services, and in-home support services to ~~consumers~~ MEMBERS. This compensation ~~shall be~~ IS provided in addition to the rate of compensation that the employee was receiving as of June 30, 2019. For an employee who was hired after June

30, 2019, the home care agency shall use the lowest compensation paid to an employee of similar functions and duties as of June 30, 2019, as the base compensation to which the increase is applied.

SECTION 96. In Colorado Revised Statutes, 25.5-6-1803, **amend** (1)(b), (1)(c) introductory portion, and (1)(e)(IV) as follows:

25.5-6-1803. Development of spending plan. (1) In accordance with federal guidance issued by the federal centers for medicare and medicaid services regarding the implementation of section 9817 of the "American Rescue Plan Act", the state department shall develop a proposed spending plan using the enhanced funding, which plan may include but is not limited to the following components:

(b) Incorporation of feedback from medical assistance ~~recipients~~ MEMBERS, advocates, and providers for the services for which the "American Rescue Plan Act" provides additional federal financial participation;

(c) Expedition of the response and recovery for medical assistance ~~recipients~~ MEMBERS, providers, and other relevant organizations most significantly impacted by the COVID-19 pandemic. Response and recovery efforts may include but are not limited to:

(e) Investment in infrastructure and technology innovation that has a long-term benefit to the system and the people of Colorado, including integration with other statewide and local efforts. Investments may include but are not limited to:

(IV) Expanding ~~recipient~~ MEMBER access to technology and technology literacy training;

SECTION 97. In Colorado Revised Statutes, 25.5-8-103, **amend** (6)(b) as follows:

25.5-8-103. Definitions - rules. As used in this article 8, unless the context otherwise requires:

(6) "Essential community provider" means a health-care provider that:

(b) Waives charges or charges for services on a sliding scale based on income and does not restrict access or services because of a ~~client's~~ MEMBER'S financial limitations.

SECTION 98. In Colorado Revised Statutes, 25.5-8-107, **amend** (1)(a)(III) as follows:

25.5-8-107. Duties of the department - schedule of services - premiums - copayments - subsidies - purchase of childhood immunizations. (1) In addition to any other duties pursuant to this article 8, the department has the following duties:

(a) (III) In addition to the items specified in ~~subparagraphs (I) and (II) of this paragraph (a)~~ SUBSECTION (1)(a)(I) AND (1)(a)(II) OF THIS SECTION and any additional items approved by the medical services board, the medical services board shall include mental health services that are at least as comprehensive as the mental health services provided to medicaid ~~recipients~~ MEMBERS in the schedule of health-care services.

SECTION 99. In Colorado Revised Statutes, 25.5-8-109, **amend** (4.5)(a)(II) and (4.5)(a)(III) as follows:

25.5-8-109. Eligibility - children - pregnant women - rules - repeal. (4.5) (a) (II) The department shall annually verify the ~~recipient's~~ MEMBER'S income eligibility at reenrollment through federally approved electronic data sources. If a ~~recipient~~ MEMBER meets all eligibility requirements, a ~~recipient~~ MEMBER remains enrolled in the plan. The department shall also allow a ~~recipient~~ MEMBER to provide income

information more recent than the records of federally approved electronic data sources.

(III) If the state department determines that a ~~recipient~~ MEMBER was not eligible for medical benefits solely based upon the ~~recipient's~~ MEMBER'S income after the ~~recipient~~ MEMBER had been determined to be eligible based upon information verified through federally approved electronic data sources, the state department shall not pursue recovery from a county department for the cost of medical services provided to the ~~recipient~~ MEMBER, and the county department is not responsible for any federal error rate sanctions resulting from ~~such~~ THE determination.

SECTION 100. In Colorado Revised Statutes, 25.5-8-110, **amend** (4)(b), (5), and (9) as follows:

25.5-8-110. Participation by managed care plans. (4) (b) The managed care organization shall seek proposals from each essential community provider in a county in which the managed care organization is enrolling ~~recipients~~ MEMBERS for those services that the managed care organization provides or intends to provide and that an essential community provider provides or is capable of providing. To assist managed care organizations in seeking proposals, the department shall provide managed care organizations with a list of essential community providers in each county. The managed care organization shall consider ~~such~~ THE proposals in good faith and shall, when deemed reasonable by the managed care organization based on the needs of its ~~enrollees~~ MEMBERS, contract with essential community providers. Each essential community provider ~~shall~~ MUST be willing to negotiate on reasonably equitable terms with each managed care organization. Essential community providers making proposals ~~under~~ PURSUANT TO this

subsection (4) ~~shall~~ MUST be able to meet the contractual requirements of the managed care organization. The requirement of this subsection (4) ~~shall~~ DOES not apply to a managed care organization in areas in which the managed care organization operates entirely as a group model health maintenance organization.

(5) The department may receive and act upon complaints from ~~enrollees~~ MEMBERS regarding failure to provide covered services or efforts to obtain payment, other than authorized copayments, for covered services directly from eligible ~~recipients~~ MEMBERS.

(9) The department shall allow, at least annually, an opportunity for ~~enrollees~~ MEMBERS to transfer among participating managed care plans serving their respective geographic regions. The department shall establish a period of at least twenty days annually when ~~this~~ THE opportunity TO TRANSFER is afforded TO eligible ~~recipients~~ MEMBERS. In geographic regions served by more than one participating managed care plan, the department shall endeavor to establish a uniform period for ~~such~~ THE opportunity TO TRANSFER.

SECTION 101. In Colorado Revised Statutes, 25.5-10-211.5, **amend** (3)(f), (3)(g), and (4)(f) as follows:

25.5-10-211.5. Conflict-free case management - implementation - legislative declaration - definition - repeal. (3) A conflict-free case management system shall be implemented in Colorado as follows:

(f) No later than June 30, 2021, at least twenty-five percent of ~~clients~~ MEMBERS receiving home- and community-based services must be served through a system of conflict-free case management; and

(g) No later than June 30, 2022, all ~~clients~~ MEMBERS receiving home- and community-based services must be served through a system of

conflict-free case management.

(4) **Rural-based services - exemption.** (f) In order to ensure stability, ~~client~~ MEMBER choice, and access to services in rural communities, the state board shall promulgate rules, as permitted under federal law, that allow a qualified entity to provide both case management services and home- and community-based services to the same individual if there is insufficient choice or capacity among existing service agencies or case management agencies serving a designated service area of a rural community-centered board.

SECTION 102. In Colorado Revised Statutes, 25.5-10-212, **amend** (1) introductory portion as follows:

25.5-10-212. Procedure for resolving disputes over eligibility, modification of services or supports, and termination of services or supports. (1) Every state or local service agency receiving state money pursuant to section 25.5-10-206 shall adopt a procedure for the resolution of disputes arising between the service agency and any ~~recipient~~ MEMBER of, or applicant for, services or supports authorized pursuant to section 25.5-10-206. Procedures for the resolution of disputes regarding early intervention services must comply with IDEA and with part 4 of article 3 of title 26.5. The procedures must be consistent with rules promulgated by the state board pursuant to article 4 of title 24 and must apply to the following disputes:

SECTION 103. In Colorado Revised Statutes, 25-48-115, **amend** (4) as follows:

25-48-115. Insurance or annuity policies. (4) An individual with a terminal illness who is a ~~recipient~~ MEMBER of medical assistance under the "Colorado Medical Assistance Act", articles 4, 5, and 6 of title 25.5,

~~C.R.S.~~ shall not be denied benefits under the medical assistance program or have ~~his or her~~ THE MEMBER'S benefits under the program otherwise altered based on whether or not the ~~individual~~ MEMBER makes a request pursuant to this ~~article~~ ARTICLE 48.

SECTION 104. In Colorado Revised Statutes, 26-7-107, **amend** (3)(b)(I) as follows:

26-7-107. Determination of benefits - adoption assistance agreement - review - definitions. (3) (b) (I) In addressing the needs of an eligible adopted child or youth, adoptive parents may knowingly take on additional costs for items or services for the child or youth being adopted, which items or services are otherwise covered costs under the medical assistance program established in articles 4, 5, and 6 of title 25.5 and identified as benefits in section 26-7-106 (2)(b). The limitations on ~~recipient~~ MEMBER payments contained in sections 24-31-808 and 25.5-4-301 do not apply to ~~such~~ THE additional costs so long as the adoptive parents consent to bear the costs as provided in subsection (3)(b)(II) of this section, and so long as the provisions of this subsection (3)(b) are not prohibited under federal law.

SECTION 105. In Colorado Revised Statutes, **repeal** 25.5-1-114.5.

SECTION 106. Act subject to petition - effective date. This act takes effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly; except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part will not take effect unless approved by the people at the general election to be held in

November 2024 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.