Second Regular Session
Seventy-third General Assembly
STATE OF COLORADO

ENGROSSED

This Version Includes All Amendments Adopted on Second Reading in the House of Introduction

LLS NO. 22-0758.01 Shelby Ross x4510

SENATE BILL 22-156

SENATE SPONSORSHIP

Kolker and Fenberg,

HOUSE SPONSORSHIP

Amabile and Young,

Senate Committees
Health & Human Services

House Committees

A BILL FOR AN ACT

CONCERNING PLACING LIMITATIONS ON PREPAID INPATIENT HEALTH PLANS, AND, IN CONNECTION THEREWITH, REMOVING PRIOR AUTHORIZATION FOR OUTPATIENT PSYCHOTHERAPY AND LIMITING WHEN A PREPAID INPATIENT HEALTH PLAN CAN RETROACTIVELY RECOVER PROVIDER PAYMENTS.

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.)

The bill prohibits a prepaid inpatient health plan from:

- Requiring prior authorization for outpatient psychotherapy

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.
Capital letters or bold & italic numbers indicate new material to be added to existing statute.
Dashes through the words indicate deletions from existing statute.

SENATE
Amended 2nd Reading
April 6, 2022

services;

- Recovering provider payments if a recipient was initially determined to be eligible for medical benefits; and
- Retroactively recovering provider payments after 12 months from the date a claim was paid, except in certain circumstances.

If a prepaid inpatient health plan retroactively recovers a provider payment that is equal to or greater than $1,000, the bill requires the prepaid inpatient health plan to work with the provider to develop a payment plan if the provider requests a payment plan.

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

SECTION 1. In Colorado Revised Statutes, 25.5-5-406.1, **amend** (1)(j) and (1)(p) 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:

(j) (I) The MCE shall not interfere with appropriate medical care decisions rendered by its contracted network providers;

(II) A PREPAID INPATIENT HEALTH PLAN SHALL NOT REQUIRE PRIOR AUTHORIZATION FOR OUTPATIENT PSYCHOTHERAPY SERVICES, AS DEFINED IN THE MOST RECENT VERSION OF THE "CURRENT PROCEDURAL TERMINOLOGY", AS DEVELOPED AND COPYRIGHTED BY THE AMERICAN MEDICAL ASSOCIATION OR ITS SUCCESSOR ENTITY;

(p) (I) The MCE shall administer a program integrity system to ensure compliance with all requirements established by the federal government, state of Colorado, state department, and state board that includes, but is not limited to:

~~(I)~~ (A) Procedures to detect and prevent fraud, waste, and abuse;

~~(II)~~ (B) Screening and disclosure processes to prevent relationships with individuals or entities that are debarred, suspended, or otherwise excluded from participating in any federal health-care program, procurement activities, or nonprocurement activities; and

~~(III)~~ (C) Treatment of recoveries of overpayment to providers;

(II) PREPAID INPATIENT HEALTH PLANS SHALL NOT RETROACTIVELY RECOVER PROVIDER PAYMENTS IF:

(A) A RECIPIENT 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; OR

(B) THE PREPAID INPATIENT HEALTH PLAN MAKES AN ERROR PROCESSING THE CLAIM BUT THE CLAIM IS OTHERWISE ACCURATELY SUBMITTED BY THE PROVIDER.

(III) (A) PREPAID INPATIENT HEALTH PLANS SHALL NOT RETROACTIVELY RECOVER PROVIDER PAYMENTS AFTER TWELVE MONTHS FROM THE DATE A CLAIM WAS PAID, EXCEPT WHEN MEDICARE, COMMERCIAL INSURANCE, OR THIRD-PARTY LIABILITY IS THE PRIMARY PAYER FOR A CLAIM; THE CLAIM IS THE SUBJECT OF A STATE OR FEDERAL AUDIT, INCLUDING AUDITS CONTRACTUALLY REQUIRED BY THE STATE DEPARTMENT; THE CLAIM IS SUBJECT TO A LAW ENFORCEMENT INVESTIGATION; THE CLAIM SUBMITTED WAS A DUPLICATE; THE CLAIM IS FRAUDULENT; THE PROVIDER IMPROPERLY BILLED THE CLAIM; OR THE CLAIM WAS SUBMITTED WITH A BILLING CODE OR DIAGNOSIS CODE THAT INACCURATELY OR INCORRECTLY RESULTED IN REIMBURSEMENT OR BYPASSED PRIOR AUTHORIZATION REQUIREMENTS.

(B) IF A PREPAID INPATIENT HEALTH PLAN RETROACTIVELY RECOVERS A PROVIDER PAYMENT THAT IS EQUAL TO ONE THOUSAND DOLLARS OR MORE, THE PREPAID INPATIENT HEALTH PLAN SHALL WORK WITH THE PROVIDER TO DEVELOP A PAYMENT PLAN IF THE PROVIDER REQUESTS A PAYMENT PLAN.

SECTION 2. Act subject to petition - effective date. This act takes effect January 1, 2023; 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 the ninety-day period after final adjournment of the general assembly, 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 2022 and, in such case, will take effect January 1, 2023, or on the date of the official declaration of the vote thereon by the governor, whichever is later.