

Colorado Revised Statutes 2013

TITLE 25.5

HEALTH CARE POLICY AND FINANCING

ADMINISTRATION

ARTICLE 1

Department of Health Care Policy and Financing

PART 1

GENERAL PROVISIONS

25.5-1-101. Short title. This title shall be known and may be cited as the "State Health Care Policy and Financing Act".

25.5-1-102. Legislative declaration. (1) The general assembly declares that state and local policymakers and health and human services administrators recognize that the management of and the delivery system for health and human services have become complex, fragmented, and costly and that the health and human services delivery system in this state should be restructured to adequately address the needs of Colorado citizens.

(2) The general assembly further finds and declares that a continuing budget crisis makes it unlikely that funding sources will keep pace with the increasing demands of health and human services.

(3) Therefore, the general assembly finds that it is appropriate to restructure principal departments responsible for overseeing the delivery of health and human services and to reform the state's health and human services administration and delivery system, using guiding principles and within the time frames set forth in article 1.7 of title 24, C.R.S., as said article existed prior to July 1, 1997. It is the general assembly's intent that the departments of public health and environment, health care policy and financing, and human services be operational, effective July 1, 1994.

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

(1) "County board" means the county or district board of social services; except that, in the city and county of Denver, "county board" means the department or agency with the responsibility for public assistance and welfare activities, and, in the city and county of Broomfield, "county board" means the city council or a board or commission with the responsibility for public assistance and welfare activities appointed by the city and county of Broomfield.

(2) "County department" means the county or district department of social services.

(3) "County director" means the director of the county or district department of social services.

(4) "Executive director" means the executive director of the department of health care policy and financing.

(5) "Medical assistance" means any program administered by the state department, including but not limited to the "Colorado Medical Assistance Act", as specified in articles 4, 5, and 6 of this title, the "Children's Basic Health Plan Act", article 8 of this title, the old age pension health and medical care program, and the supplemental old age pension health and medical care program; except that "medical assistance" for purposes of articles 4, 5, and 6 of this title shall have the meaning as defined in section 25.5-4-103 (13).

(5.5) "Medical home" means an appropriately qualified medical specialty, developmental, therapeutic, or mental health care practice that verifiably ensures continuous, accessible, and comprehensive access to and coordination of community-based medical care, mental health care, oral health care, and related services for a child. A medical home may also be referred to as a health care home. If a child's medical home is not a primary medical care provider, the child must have a primary medical care provider to ensure that a child's primary medical care needs are appropriately addressed. All medical homes shall ensure, at a minimum, the following:

- (a) Health maintenance and preventive care;
- (b) Anticipatory guidance and health education;
- (c) Acute and chronic illness care;
- (d) Coordination of medications, specialists, and therapies;
- (e) Provider participation in hospital care; and
- (f) Twenty-four-hour telephone care.

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

(7) "State board" or "board" means the medical services board created pursuant to section 25.5-1-301.

(8) "State department" means the department of health care policy and financing.

(9) "State designated agency" means an agency designated to perform specified functions that would otherwise be performed by the county departments, including the single entry point agencies and medical assistance sites.

25.5-1-104. Department of health care policy and financing created - executive director - powers, duties, and functions. (1) There is hereby created the department of health care policy and financing, the head of which shall be the executive director of the department of health care policy and financing, which office is hereby created. The executive director shall be appointed by the governor, with the consent of the senate, and shall serve at the pleasure of the governor. The reappointment of an executive director after an initial election of a governor shall be subject to the provisions of section 24-20-109, C.R.S. The executive director has those powers, duties, and functions prescribed for the heads of principal departments in the "Administrative Organization Act of 1968", article 1 of title 24, C.R.S., and any powers, duties, and functions set forth in this title.

(2) The department of health care policy and financing shall consist of an executive director of the department of health care policy and financing, the medical services board, and such divisions, sections, and other units as shall be established by the executive director pursuant to the provisions of subsection (3) of this section.

(3) The executive director may establish such divisions, sections, and other units within the state department as are necessary for the proper and efficient discharge of the powers, duties, and functions of the state department; except that such action by the executive director shall not conflict with the implementation requirements for the plan for restructuring the delivery of health and human services in this state, as set forth in article 1.7 of title 24, C.R.S.

(4) The department of health care policy and financing shall be responsible for the administration of the functions and programs as set forth in this title.

(5) (a) The executive director of the state department shall appoint an internal auditor who shall have the status of a division director and, as such, shall have the authority to appoint such personnel as may be necessary to carry out the duties of the internal auditor.

(b) The internal auditor appointed by the executive director pursuant to paragraph (a) of this subsection (5) shall:

- (I) Conduct and supervise internal audits of the state department;
- (II) Coordinate and facilitate external audits that are performed on the state department by state and federal entities;
- (III) Conduct and supervise performance audits for the purpose of determining the efficiency and effectiveness of the state department's operation and administration of programs; and

(IV) Conduct such other audits and perform such other duties as may be specified by the executive director.

25.5-1-105. Transfer of functions. (1) The state department shall, on and after July 1, 1994, execute, administer, perform, and enforce the rights, powers, duties, functions, and obligations vested prior to July 1, 1994, in the Colorado health data commission within the department of local affairs, the department of social services concerning the "Colorado Medical Assistance Act", and the university of Colorado health sciences center concerning health care for the medically indigent.

(2) All rules, regulations, and orders of the department of local affairs, the state department of social services, the state board of social services, the department of regulatory agencies, and the university of Colorado health sciences center adopted prior to July 1, 1994, in connection with the powers, duties, and functions transferred to the state department shall continue to be effective until revised, amended, repealed, or nullified pursuant to law. On and after July 1, 1994, the state board or the executive director, whichever is appropriate, shall adopt rules necessary for the administration of the state department and the administration of the programs set forth in this title.

(3) No suit, action, or other judicial or administrative proceeding lawfully commenced prior to July 1, 1994, or which could have been commenced prior to such date, by or against the department of local affairs, the state department of social services, the department of regulatory agencies, or the university of Colorado health sciences center, or any officer thereof in such officer's official capacity or in relation to the discharge of the official's duties, shall abate by reason of the transfer of duties and functions from said departments to the state department.

(4) The executive director, or a designee of the executive director, may accept, on behalf of and in the name of the state, gifts, donations, and grants for any purpose connected with the work and programs of the state department. Any property so given shall be held by the state treasurer, but the executive director, or the designee therefor, shall have the power to direct the disposition of any property so given for any purpose consistent with the terms and conditions under which such gift was created.

(5) The revisor of statutes is hereby authorized to change all references in the Colorado Revised Statutes to the department of local affairs, the state department of social services, the department of regulatory agencies, and the university of Colorado health sciences center from said references to the state department, as appropriate and with respect to the powers, duties, and functions transferred to the state department. In connection with such authority, the revisor of statutes is hereby authorized to amend or delete provisions of the Colorado Revised Statutes so as to make the statutes consistent with the powers, duties, and functions transferred pursuant to this section.

(6) On and after July 1, 2003, the powers, duties, and functions relating to the old

age pension health and medical care program, as specified in section 25.5-2-101, are transferred by a **type 2** transfer to the department of health care policy and financing.

25.5-1-105.5. Chief medical officer - qualifications. (1) The executive director shall appoint a chief medical officer who shall:

(a) Have a degree of doctor of medicine or doctor of osteopathy and be licensed to practice medicine in the state of Colorado;

(b) Have at least two years of postgraduate experience in primary care; and

(c) Have at least two years of experience in an administrative capacity in a health care organization.

(2) The chief medical officer shall, with the assistance of advisory committees of the state department, provide medical judgment and advice regarding all medical issues involving programs administered by the state department.

(3) The chief medical officer shall receive a salary within the limits of moneys made available to the state department by appropriation of the general assembly or otherwise.

25.5-1-106. Restructure of health and human services - development of plan - participation of department required. (Deleted by amendment)

25.5-1-107. Final agency action - administrative law judge - authority of executive director. (1) The executive director may appoint one or more persons to serve as administrative law judges for the state department pursuant to section 24-4-105, C.R.S., and pursuant to part 10 of article 30 of title 24, C.R.S., 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 shall be considered initial decisions of the state department and shall be reviewed by the executive director or a designee of the executive director. In the event exceptions to the initial decision are filed pursuant to section 24-4-105 (14) (a) (I), C.R.S., such review shall be in accordance with section 24-4-105 (15), C.R.S. In the absence of any exception filed pursuant to section 24-4-105 (14) (a) (I), C.R.S., the executive director shall review the initial decision in accordance with a procedure adopted by the state board. Such procedure shall be consistent with federal mandates concerning the single state agency requirement. Review by the executive director in accordance with section 24-4-105 (15), C.R.S., or the procedure adopted by the state board pursuant to this section shall constitute final agency action. The administrative law judge may conduct hearings on appeals from decisions of county departments of social services brought by recipients of and applicants for medical

assistance and welfare which 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 shall be served at least ten days prior to such hearing.

(2) Hearings initiated by a licensed or certified provider of services shall be conducted by an administrative law judge for the state department and shall be considered final agency action and subject to judicial review in accordance with the provisions of section 24-4-106, C.R.S., for any party, including the state department, which shall be considered a person for such purposes.

25.5-1-108. Executive director - rules. (1) The executive director shall have authority to promulgate rules in connection with the policies and procedures governing the administration of the department including, but not limited to, rules concerning the following:

(a) Matters of internal administration of the department, including organization, staffing, records, reports, systems, and procedures;

(b) Fiscal and personnel administration for the department;

(c) Accounting and fiscal reporting policies and procedures for disbursement of federal funds, contingency funds, and distribution of available appropriations;

(d) Such other rules relating to those functions the executive director is required to carry out pursuant to the provisions of this title.

(2) Nothing in this section shall be construed to affect any specific statutory provision granting rule-making authority in relation to a specific program to the executive director.

25.5-1-109. Department of health care policy and financing cash fund. All moneys collected by the state department as fees or otherwise shall be transmitted to the state treasurer, who shall credit the same to the department of health care policy and financing cash fund, which fund is hereby created in the state treasury. Moneys in the fund shall be subject to annual appropriation by the general assembly for the direct and indirect costs of the state department's duties as provided by law.

25.5-1-109.5. Clinical standards - development - reports. (1) The general assembly finds that:

(a) It is important to collect and analyze objective clinical standards to maximize the scarce dollars available for medical care; and

(b) The development of an ongoing, transparent measurement of health outcomes

is essential to ensure quality health care for Coloradans.

(2) (a) The state department, following consultation with external clinical advisors, shall develop clinical standards and methods for collecting, analyzing, and disclosing information regarding clinical performance, including but not limited to immunization rates, medical home standards, clinical care guidelines, care coordination, case management, disease management, and coordination and integration of mental health services. The standards and methods shall be consistent with national guidelines and standards regarding the collection and analysis of health data, where feasible, and shall meet the federal reporting requirements established under Titles XIX and XXI of the federal "Social Security Act", 42 U.S.C. secs. 1396 and 1397.

(b) The state department shall review data collected pursuant to paragraph (a) of this subsection (2) and assess the health outcomes for programs administered by the state department. On or before July 1, 2008, and on or before each July 1 thereafter, based on the review of this data, the state department shall recommend to the health and human services committees of the senate and the house of representatives, or any successor committees, strategies to improve health outcomes.

25.5-1-110. Study of children's access to health care coverage - acceptance of donations - repeal. (Repealed)

25.5-1-111. Waiver applications - authorization. (Deleted by amendment)

25.5-1-112. Drug-purchasing pool - report - repeal. (Repealed)

25.5-1-113. Federal authorization - repeal. (Deleted by amendment)

25.5-1-113.5. Children's access to health care - reports. (1) On or before January 1, 2008, and on or before each January 1 thereafter, the state department shall submit a report to the health and human services committees of the senate and the house of representatives, or any successor committees, on measures of access to and quality of health care for children eligible for programs pursuant to this title, including but not limited to data showing whether:

(a) Providers for children are participating in the programs and are accepting eligible children as patients on a regular basis;

(b) Eligible children are enrolling in programs under this title and are remaining enrolled so that the children have continuity of care;

(c) Eligible children are receiving the early and periodic screening, diagnosis, and treatment services required by federal law, including but not limited to regular preventive care and, when appropriate, timely specialty care, and that providers are accurately reporting the data from these visits; and

(d) Providers are using other appropriate measures of access and quality to improve health outcomes and maximize the expenditure of health care resources.

25.5-1-114. Grants-in-aid - county supervision. (1) The state department shall consult with and coordinate with the counties before making any changes that affect county operations in the implementation of this section, when possible under state statutes and federal statutes and regulations.

(2) In administering any funds appropriated or made available to the state department for medical assistance administration, the state department has the power to:

(a) Require as a condition for receiving grants-in-aid that each county in this state shall bear the proportion of the total expense of furnishing medical assistance administration as is fixed by law relating to such assistance;

(b) Terminate any grants-in-aid to any county of this state if the laws and regulations providing such grants-in-aid and the minimum standards prescribed by rules of the state department thereunder are not complied with;

(c) Undertake forthwith the administration of any or all medical assistance within any county of this state which has had any or all of its grants-in-aid terminated pursuant to paragraph (b) of this subsection (2); but the county shall continue to meet the requirements of paragraph (a) of this subsection (2);

(d) Recover any moneys owed by a county to the state by reducing the amount of any payments due from the state in connection with the administration of medical assistance;

(e) Take any other action which may be necessary or desirable for carrying out the provisions of this title.

(3) The state department, under the supervision of the executive director, shall provide supervision of county departments for the effective administration of medical assistance as set out in the rules of the executive director and the rules of the state board pursuant to section 25.5-1-301; except that nothing in this subsection (3) shall be construed to allow counties to continue to receive an amount equal to the increased funding in the event the said funding is no longer available from the federal government.

25.5-1-114.5. Medicaid fraud detection - request for information. (1) In enacting this section, the general assembly intends to:

(a) Implement waste, fraud, and abuse detection, prevention, and recovery

solutions to improve program integrity in the state's medicaid program and create efficiency and cost savings through a shift from a retrospective "pay and chase" model to a prospective prepayment model; and

(b) Invest in the most cost-effective technologies or strategies that yield the highest return on investment.

(2) By September 30, 2013, the state department shall issue a request for information to seek input from potential contractors on capabilities that the state department does not currently possess, functions that the state department is not currently performing, and the cost structures associated with implementing:

(a) Advanced predictive modeling and analytics technologies to provide a comprehensive and accurate view across all providers, recipients, and geographic locations within the medicaid program in order to:

(I) Identify and analyze those billing and utilization patterns that represent a high risk of fraudulent activity;

(II) Be easily integrated into the existing medicaid program claims operations;

(III) Undertake and automate such analysis before payment is made to minimize disruptions to state department operations and speed claim resolution;

(IV) Prioritize the identified transactions for additional review before payment is made based upon the likelihood of potential waste, fraud, or abuse;

(V) Obtain outcome information from adjudicated claims to allow for refinement and enhancement of the predictive analytics technologies based on historical data and algorithms with the system; and

(VI) Prevent the payment of claims for reimbursement that have been identified as potentially wasteful, fraudulent, or abusive until the claims have been automatically verified as valid;

(b) Provider and recipient data verification and screening technology solutions, which may use publicly available records, for the purposes of automating reviews and identifying and preventing inappropriate payments by:

(I) Identifying associations between providers, practitioners, and beneficiaries that indicate rings of collusive fraudulent activity; and

(II) Discovering recipient attributes that indicate improper eligibility, including but not limited to death, out-of-state residency, inappropriate asset ownership, or incarceration; and

(c) Fraud investigation services that combine retrospective claims analysis and prospective waste, fraud, or abuse detection techniques. These services must include analysis of historical claims data, medical records, suspect provider databases, and high-risk identification lists, as well as direct recipient and provider interviews. Emphasis must be placed on the state department providing education to providers and allowing them the opportunity to review and correct any problems identified prior to administrative proceedings.

(3) In addition to the information provided pursuant to subsection (2) of this section, a potential contractor responding to the request for information shall include information concerning:

(a) The extent to which the potential contractor will seek clinical and technical expertise from Colorado providers concerning the design and implementation of the medicaid fraud detection system described in this section and the method or methods for seeking that expertise; and

(b) The potential contractor's ability to create an education and outreach program that is widely available and easily accessible to Colorado providers for purposes of educating providers on issues relating to coverage and coding.

(4) (a) The state department is encouraged to use the results of the request for information to create formal requests for proposals to carry out the work identified in this section if the following conditions are met:

(I) The state department expects to generate state savings by preventing fraud, waste, and abuse;

(II) This work can be integrated into the state department's current medicaid operations without creating additional costs to the state; and

(III) The reviews or audits are not anticipated to delay or improperly deny the payment of legitimate claims to providers.

(b) Prior to awarding any contract pursuant to this section, the state department shall establish an appeal process for providers that minimizes the administrative burden placed on providers, limits the number of medical records requests, and provides adequate time for providers to respond to inquiries.

(5) It is the intent of the general assembly that the savings achieved through this section must more than cover the cost of implementation and administration. Therefore, to the extent possible, technology services used in carrying out this section must be secured using the savings generated by the program, with the state's direct cost funded through the actual savings achieved.

25.5-1-115. Locating violators - recoveries. (1) The executive director of the state department, or district attorneys may request and shall receive from departments, boards, bureaus, or other agencies of the state or any of its political subdivisions, and the same are authorized to provide, such assistance and data as will enable the state department and county departments properly to carry out their powers and duties to locate and prosecute any person who has fraudulently obtained medical assistance under this title. Any records established pursuant to the provisions of this section shall be available only to the state department, the department of human services, the county departments, the attorney general, and the district attorneys, county attorneys, and courts having jurisdiction in fraud or recovery proceedings or actions.

(2) (a) All departments and agencies of the state and local governments shall cooperate in the location and prosecution of any person who has fraudulently obtained medical assistance under this title, and, on request of the county board, the county director, the state department, or the district attorney of any judicial district in this state, shall supply all information on hand relative to the location, employment, income, and property of such persons, notwithstanding any other provision of law making such information confidential, except the laws pertaining to confidentiality of any tax returns filed pursuant to law with the department of revenue. The department of revenue shall furnish at no cost to inquiring departments and agencies such information as may be necessary to effectuate the purposes of this article. The procedures whereby this information will be requested and provided shall be established by rule of the state department. The state department or county departments shall use such information only for the purposes of administering medical assistance under this title, and the district attorney shall use it only for the prosecution of persons who have fraudulently obtained medical assistance under this title, and shall not use the information, or disclose it, for any other purpose.

(b) (I) Whenever the state department, or a district attorney for the state department, or the state department on behalf of a county department, recovers any amount of fraudulently obtained medical assistance funds, the federal government shall be entitled to a share proportionate to the amount of federal funds paid unless a different amount is otherwise provided by federal law, the state shall be entitled to a share proportionate to the amount of state funds paid and such additional amounts of federal funds recovered as provided by federal law, and the county department shall be entitled to a share proportionate to the amount of county funds paid unless a different amount is provided pursuant to federal law or this section.

(II) (A) Whenever a county department, a county board, a district attorney, or a state department on behalf of a county department recovers any amount of fraudulently obtained public assistance funds in the form of assistance payments, it shall be deposited in the county social services fund, and the federal government 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 is entitled to a share proportionate to one-half the amount of state funds paid, and the county is entitled to a share proportionate to the amount of county funds paid and, in addition, a share proportionate to one-half the amount of state funds paid.

(B) Whenever a county department, a county board, a district attorney, or a state department on behalf of a county department recovers any amount of fraudulently obtained medical assistance, it shall be deposited in the county social services fund, and the federal government is entitled to a share proportionate to the amount of federal funds paid, unless a different amount is provided for by federal law, and the county is entitled to the remaining funds.

(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 error, the federal government shall be 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 entitled to a share proportionate to seventy-five percent of the amount of state funds paid, the county shall be 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.

(4) Actual costs and expenses incurred by the district attorney's office in carrying out the provisions of subsection (2) of this section shall be billed to counties or a county within the judicial district in the proportions specified in section 20-1-302, C.R.S. Each county shall make an annual accounting to the state department on all amounts recovered.

25.5-1-115.5. Medical assistance client fraud - report. (1) On or before January 15, 2013, and on or before January 15 each year thereafter, the state department shall submit a written report to the judiciary committee and the health and environment committee of the house of representatives, or their successor committees, and to the judiciary committee and the health and human services committee of the senate, or their successor committees, relating to fraudulent receipt of medicaid benefits including, at a minimum:

- (a) Investigations of client fraud during the year;
- (b) Termination of client medicaid benefits due to fraud;
- (c) District attorney action, including, at a minimum, criminal complaints requested, cases dismissed, cases acquitted, convictions, and confessions of judgment;
- (d) Recoveries, including fines and penalties, restitution ordered, and restitution collected; and
- (e) Trends in methods used to commit client fraud, excluding law enforcement-sensitive information.

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, and former and potential recipients of medical assistance to purposes directly connected with the administration of such medical assistance and related state department activities and covering the custody, use, and preservation of the records, papers, files, and communications of the state and county departments. Whenever, under provisions of law, names and addresses of applicants for, recipients of, or former and potential recipients of

medical assistance are furnished to or held by another agency or department of government, such agency or department shall be required to prevent the publication of lists thereof and their uses for purposes not directly connected with the administration of such medical assistance.

(2) (a) (I) Except as provided in subparagraphs (II) and (III) of this paragraph (a), it is unlawful for any person to solicit, disclose, or make use of or to authorize, knowingly permit, participate in, or acquiesce in the use of any lists or names of or any information concerning persons applying for or receiving public assistance and welfare directly or indirectly derived from the records, papers, files, or communications of the state or county departments or subdivisions or agencies thereof or acquired in the course of the performance of official duties. No financial institution or insurance company that provides the data, whether confidential or not, required by the state department, in accordance with the provisions of this subsection (2), shall be liable for the provision of the data to the state department nor for any use made thereof by the state department.

(II) The information described in subparagraph (I) of this paragraph (a) may be disclosed for purposes directly connected with the administration of medical assistance and in accordance with this paragraph (a) and paragraphs (b) and (c) of this subsection (2) and with the rules of the state department.

(III) (A) Notwithstanding any provision of state law to the contrary and to the extent allowable under federal law, at the request of the Colorado bureau of investigation, the state department shall provide the bureau with information concerning the location of any person whose name appears in the department's records who is the subject of an outstanding felony arrest warrant. Upon receipt of such information, it shall be the responsibility of the bureau to provide appropriate law enforcement agencies with location information obtained from the state department. Location information provided pursuant to this section shall be used solely for law enforcement purposes. The state department and the bureau shall determine and employ the most cost-effective method for obtaining and providing location information pursuant to this section. Neither the state department nor its employees or agents shall be liable in civil action for providing information in accordance with the provisions of this sub-subparagraph (A).

(B) As used in sub-subparagraph (A) of this subparagraph (III), "law enforcement agency" means any agency of the state or its political subdivisions that is responsible for enforcing the laws of this state. "Law enforcement agency" includes but is not limited to any police department, sheriff's department, district attorney's office, the office of the state attorney general, and the Colorado bureau of investigation.

(b) By signing an application or redetermination of eligibility form for medical assistance, an applicant authorizes the state department to obtain records pertaining to information provided in that application or redetermination of eligibility form from a financial institution, as defined in section 15-15-201 (4), C.R.S., or from any insurance company. The application or redetermination of eligibility form shall contain language

clearly indicating that signing constitutes such an authorization.

(c) (I) In order to determine if applicants for or recipients of medical assistance have assets within eligibility limits, the state department may provide a list of information identifying these applicants or recipients to any financial institution, as defined in section 15-15-201 (4), C.R.S., or to any insurance company. This information may include identification numbers or social security numbers. The state department may require any such 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, 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 and inform the recipient of the apparent results of the computer match and give the recipient the opportunity to explain or correct any erroneous information secured by the match. The requirement to run a computerized match shall apply 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 require any such institution or company to change its data or make new entries for the purpose of comparing identifying information. The cost of providing such computerized match shall be borne by the state department.

(II) For the fiscal year beginning July 1, 1984, and thereafter, all funds expended by the state department to pay the cost of providing such computerized matches shall be subject to an annual appropriation by the general assembly.

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

(d) No applicant shall be denied nor any recipient discontinued due to the disclosure of their assets unless and until the county department or medical assistance site has assured that such 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 applicant's or recipient's eligibility for other medical assistance is affected.

(3) The applicant for or recipient of medical assistance, or his or her representative, shall have an opportunity to examine all applications and pertinent records concerning said applicant or recipient which constitute a basis for denial, modification, or termination of such medical assistance or to examine such records in case of a fair hearing.

(4) Any person who violates subsection (1) or (2) of this section is guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not more than five hundred dollars, or by imprisonment in the county jail for not more than three months, or by both such fine and imprisonment.

25.5-1-117. County departments - district departments. (1) Except as provided in subsection (2) of this section, there shall be established in each county of the state a county department of social services that shall consist of a county board of social services, a county director of social services, and any additional employees as may be necessary for the efficient performance of public assistance, as defined in section 26-2-103 (7), C.R.S., and medical assistance.

(2) Single entry point agencies established pursuant to part 1 of article 6 of this title, other than county departments acting as single entry point agencies, may act as state designated agencies and are hereby authorized to carry out functions as specified in part 1 of article 6 of this title that are otherwise performed by county departments.

(3) With the approval of the department of human services, two or more counties may jointly establish a district department of social services. All duties and responsibilities for county departments set forth in this title shall also apply to district departments of social services.

25.5-1-118. Duties of county departments. (1) The county departments or other state designated agencies, where applicable, shall serve as agents of the state department and shall be charged with the administration of medical assistance and related activities in the respective counties in accordance with the rules of the state department.

(2) The county departments or other state designated agencies, where applicable, shall report to the state department at such times and in such manner and form as the state department may from time to time direct.

(3) The county department or other state designated agencies, where applicable, in each county shall submit quarterly and annually to the board of county commissioners a budget containing an estimate and supporting data setting forth the amount of money needed to carry out the provisions of this title.

25.5-1-119. County staff. The county director, with the approval of the county board, shall appoint such staff as may be necessary as determined by the state department rules to administer medical assistance within the county. The staff shall be appointed and shall serve in accordance with a merit system for the selection, retention, and promotion of county department employees as described in section 26-1-120, C.R.S. The salaries of the staff members shall be fixed in accordance with the rules and salary schedules prescribed by the state department or the department of human services, whichever is appropriate; except that, once a county transfers its county employees to a successor merit system as provided in section 26-1-120, C.R.S., the salaries shall be fixed by the county commissioners.

25.5-1-120. Appropriations. (1) (a) For carrying out the duties and obligations of the state department and county departments under the provisions of this title and for matching such federal funds or meeting maintenance of effort requirements as may be available for public assistance and welfare activities in the state, including medical assistance administration and related activities, the general assembly, in accordance with the constitution and laws of the state of Colorado, shall make adequate appropriations for the payment of such costs, pursuant to the budget prepared by the executive director.

(b) If the federal law shall provide federal funds, in cash or in another form such as medical assistance, not otherwise provided for in this title, the state department is authorized to make such payments or offer such services in accordance with the requirements accompanying said federal funds within the limits of available state appropriations.

(c) When the executive director determines that adequate appropriations for the payment of the costs described in paragraph (a) of this subsection (1) have not been made and that an overexpenditure of an appropriation will occur based upon the state department's estimates, the state board may take actions consistent with state and federal law to bring the rate of expenditure into line with available funds. The general assembly declares that case load and utilization based on medical necessity are legitimate reasons for supplemental funding.

(2) The general assembly shall appropriate from the general fund to the state department moneys for the costs of administering medical assistance programs and the state's share of the costs of administering such functions by the county departments amounts sufficient for the proper and efficient performance of the duties imposed upon them by law, including a legal advisor appointed by the attorney general. The general assembly shall make two separate appropriations, one for the administrative costs of the state department and another for the administrative costs of the county departments. Any applicable matching federal funds shall be apportioned in accordance with the federal regulations accompanying such funds. Any unobligated and unexpended balances of appropriated state general funds remaining at the end of each fiscal year shall be credited to the state general fund.

(3) The expenses of training personnel for special skills relating to medical assistance, as such expenses shall be determined and approved by the state department, may be paid from state and federal funds available for such training purposes.

25.5-1-121. County expenditures - advancements - procedures. (1) For purposes of this article, under rules of the state department, administrative costs shall include: Salaries of the county director and employees of the county department staff engaged in the performance of medical assistance activities; the county's payments on behalf of such employees for old age and survivors' insurance or pursuant to a county

officers' and employees' retirement plan and for any health insurance plan, if approved by the state department; the necessary travel expenses of the county board and the administrative staff of the county department in the performance of their duties; necessary telephone and other electronic means of communication; necessary equipment and supplies; necessary payments for postage and printing, including the printing and preparation of county warrants required for the administration of the county department; and such other administrative costs as may be approved by the state department; but advancements for office space, utilities, and fixtures may be made from state funds only if federal matching funds are available.

(2) Notwithstanding any other provision of this article, the county department may spend in excess of twenty percent of actual costs for the purpose of matching federal funds for the administration of the child support enforcement program or for the administrative costs of activities involving food stamp, public assistance, or medical assistance fraud investigations or prosecutions.

(3) (a) Notwithstanding any other provision of this article, the county department may receive and spend federal funds to which it is entitled based on the county's certification of public expenditures for administrative costs made by other entities within the county, which expenditures:

(I) Are from sources other than the county social services fund;

(II) Are in excess of the county department's portion, as required pursuant to section 25.5-1-114 (2) (a), of the administrative costs; and

(III) Are for an administrative activity that has been approved by the state department as an activity that is eligible for reimbursement under a federal program.

(b) Acceptance and expenditure of federal funds pursuant to paragraph (a) of this subsection (3) shall not affect the state's share of and contribution to the administrative costs. The county shall be solely responsible for certifying the nonfederal share that is in excess of the county's required portion of the administrative costs. The state department may retain up to five percent of any federal funds received by a county department pursuant to this subsection (3). In addition, the state, in accordance with the provisions of section 26-1-109 (4) (d), C.R.S., shall recover any federal funds received by the county through the certification of public expenditures that are subsequently determined to be ineligible for federal reimbursement.

25.5-1-122. County appropriation increases - limitations. (1) Beginning in calendar fiscal year 1994 and for each calendar fiscal year thereafter to and including calendar fiscal year 1997, the board of county commissioners in each county of this state shall annually appropriate funds for the county share of the administrative costs of medical assistance in the county in an amount equal to the actual county share for the previous fiscal year adjusted by an amount equal to the actual county share for the

previous fiscal year multiplied by the percentage of change in property tax revenue.

(2) For the purposes of this section:

(a) "County share" means the actual amount of the county share for the previous fiscal year. "County share" shall not include:

(I) The amount expended by the county from the county contingency fund or the county tax base relief fund pursuant to section 26-1-126, C.R.S.;

(II) The amount expended by the county for general assistance pursuant to part 1 of article 17 of title 30, C.R.S.; and

(III) The amount expended by the county for programs or services provided by the county on its own, without requirements or funding from any other governmental agency.

(b) "Percentage of change in property tax revenue" means the difference between the total property tax levied for the previous fiscal year less the amount levied for debt service for the previous fiscal year and the total property tax levied for the year for which the percentage of change in tax revenue is being calculated less the amount levied for debt service for the year in which the percentage of change in tax revenue is being calculated divided by the total property tax levied for the previous fiscal year less the amount levied for debt service for the previous fiscal year.

(3) Notwithstanding the provisions of section 25.5-1-121, a county in the state shall not be required to contribute more than the amount set forth in subsection (1) of this section in any fiscal year. Nothing in this section shall be construed to limit the ability of a county to establish programs or services provided by the county on its own, without requirements or funding from any other governmental agency.

(4) (Deleted by amendment, L. 2008, p. 1812, § 3, effective June 2, 2008.)

(5) Any amounts remaining in the county social services fund created in section 26-1-123, C.R.S., at the end of any fiscal year shall remain in the county fund for expenditure as determined by the board of county commissioners for administrative costs of public assistance, medical assistance, and food stamps, and program costs of public assistance and food stamps.

(6) The limitation set forth in this section on the increase in the county share of the administrative costs of medical assistance will result in increased costs to the state. By making state funds available, the state is encouraging counties not to exercise any right a county may have pursuant to section 20 (9) of article X of the Colorado constitution to reduce or end its share of the costs of medical assistance administration for the county for three fiscal years following the fiscal year in which the state funds are received. If a county accepts funds from the state based on the limitation provided in this section for any fiscal year, the county agrees not to exercise any rights the county may have to reduce or end its share of the costs of medical assistance administration for the fiscal year in which the funds are accepted. Nothing in this subsection (6) or any agreement pursuant to this subsection (6) shall be construed to affect the existence or status of any rights accruing to the state or any county pursuant to section 20 (9) of article X of the Colorado

constitution.

25.5-1-123. Medical homes for children - legislative declaration - duties of the department - reporting requirements. (1) The general assembly hereby finds and declares that:

(a) The best medical care for infants, children, and adolescents is provided through a medical home, as defined in section 25.5-1-103, and that is consistent with the joint principles of a patient-centered medical home. Those principles shall include a whole-person orientation, care that is coordinated and integrated across all elements of the complex health care system and the patient's community, and care that provides for quality and safety of the patient where qualified health care practitioners provide primary care and help manage and facilitate all aspects of medical care.

(b) Infants, children, and adolescents and their families work best with a health care practitioner who knows the family and who develops a partnership of mutual responsibility and trust;

(c) Medical care provided through emergency departments, walk-in clinics, and other urgent-care facilities is often more costly and less effective than care given by a physician with prior knowledge of the child and his or her family; and

(d) The state department should strive to find a medical home for each child receiving services through the state medical assistance program, articles 4, 5, and 6 of this title, or the children's basic health plan, article 8 of this title.

(2) On or before July 1, 2008, the state department, in conjunction with the Colorado medical home initiative in the department of public health and environment, shall develop systems and standards to maximize the number of children enrolled in the state medical assistance program or the children's basic health plan who have a medical home. The systems and standards developed shall include, but need not be limited to, ways to ensure that a medical home shall offer family-centered, compassionate, culturally effective care and sensitive, respectful communication to a child and his or her family.

(3) On or before January 30, 2008, and every January 30 thereafter, the state department shall report to the health and human services committees of the house of representatives and the senate, or any successor committees, on progress made toward maximizing the number of children with a medical home who are enrolled in the state medical assistance program or the children's basic health plan.

25.5-1-124. Early intervention payment system - participation by state department - rules. (1) The state department shall participate in the development and implementation of the coordinated system of payment for early intervention services authorized pursuant to part 7 of article 10.5 of title 27, C.R.S., and Part C of the federal

"Individuals with Disabilities Education Act", 20 U.S.C. sec. 1400 et seq., as amended.

(2) The state department shall ensure that the early intervention services and payments for recipients of medical assistance under this title are integrated into the coordinated early intervention payment system developed pursuant to part 7 of article 10.5 of title 27, C.R.S. To the extent necessary to achieve the coordinated payment system and coverage of those early intervention services under this title, 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.

(3) The state department shall also make any modifications necessary to the "Children's Basic Health Plan Act", article 8 of this title, including promulgating rules, to ensure that the children's basic health plan is integrated into the coordinated early intervention payment system developed pursuant to part 7 of article 10.5 of title 27, C.R.S.

(4) Repealed.

(5) (a) As used in this section, unless the context otherwise requires, "early intervention services" means those services defined as early intervention services by the department of human services in accordance with section 27-10.5-702 (7), C.R.S., that are determined, through negotiation between the state department and the department of human services, to be medically necessary under medical assistance and cost-effective. After negotiating the scope of early intervention services to be covered under medical assistance, the state department and the department of human services shall submit to the joint budget committee of the general assembly, as part of each department's annual budget request, a proposal for the scope of coverage of early intervention services under medical assistance, including the anticipated costs of such coverage and whether the payment of such costs through medical assistance is cost-effective.

(b) "Early intervention services" shall not include the following:

(I) Nonemergency medical transportation;

(II) Respite care;

(III) Service coordination, as defined in 34 CFR 303.12 (d) (11); and

(IV) (A) Assistive technology.

(B) The exclusion of assistive technology shall not apply to durable medical equipment that is otherwise covered under the children's basic health plan, as defined in section 25.5-8-103 (2).

25.5-1-125. Centennial care choices - value benefit plans - request for information - request for proposals - report to general assembly - definitions - legislative declaration. (Repealed)

25.5-1-126. Discounted prices for durable medical equipment and supplies. (1) The state department shall work with one or more nonprofit organizations to develop a link of approved vendors who are willing to sell durable medical equipment and medical supplies at discounted prices to persons who have applied for, but are not yet receiving, benefits under the "Colorado Medical Assistance Act". The state department shall provide the exclusive criteria for a nonprofit organization to use to approve a vendor for placement on the approved vendor list.

(2) The state department shall maintain a link of approved vendors developed pursuant to this section and shall:

- (a) Make the link available on the state department's web site; and
- (b) Provide copies of the list to county departments and to sites authorized to accept medical assistance applications pursuant to section 25.5-4-205 (1), through the survey given to applicants.

25.5-1-127. Third-party benefit denials information. The state department shall provide information to recipients of benefits under this title concerning their right to appeal a denial of benefits by a third party and shall post information on the state department's web site concerning recipients' 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 web site regarding such appeals.

25.5-1-128. Provider payments - compliance with state fiscal requirements - definitions - rules. (1) (a) Notwithstanding any provision of law to the contrary, when the state department has regulatory authority over a program and when the provider has already signed a state department-approved provider application to provide a service or to bill the state department or its authorized contractor for a service, the state department-approved provider application shall serve to fulfill the requirements of a commitment voucher and the fiscal requirements of section 24-30-202 (1), C.R.S.

(b) The executive director may promulgate rules to exempt a provider who provides services through a program as described in paragraph (a) of this subsection (1) for any program the state department is authorized by law to administer, including but not limited to:

- (I) The "Colorado Medical Assistance Act", articles 4 to 6 of this title;
- (II) The "Children's Basic Health Plan Act", article 8 of this title;
- (III) The "Colorado Indigent Care Program", part 1 of article 3 of this title;
- (IV) The school health services program authorized by section 25.5-5-318;
- (V) Programs that are funded through the primary care fund, created in section 24-22-117 (2) (b), C.R.S.; and

(VI) The state-funded old age pension health and medical care program pursuant to article 2 of this title.

(2) As used in this section, unless the context otherwise provides, "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), 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 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.

PART 2

PROGRAMS TO BE ADMINISTERED BY THE DEPARTMENT

25.5-1-201. Programs to be administered by the department of health care policy and financing. (1) Programs to be administered and functions to be performed by the department of health care policy and financing shall be as follows:

(a) The "Colorado Medical Assistance Act", as specified in articles 4, 5, and 6 of this title;

(b) The "Colorado Indigent Care Program", as specified in part 1 of article 3 of this title;

(c) Effective July 1, 1996, school entry immunization, as specified in part 9 of article 4 of title 25, C.R.S. Commencing on and after the fiscal year beginning July 1, 1996, the state department is authorized to contract with the department of public health and environment for the purpose of enforcing the school entry immunization requirements.

(d) Repealed.

(e) The "Children's Basic Health Plan Act", as specified in article 8 of this title;

(f) The old age pension health and medical care program, as specified in section 25.5-2-101; and

(g) Programs, services, and supports for persons with intellectual and developmental disabilities, as specified in article 10 of this title.

Editor's note: Paragraph (g) is effective March 1, 2014.

25.5-1-202. Advisory committee on covering all children in Colorado - reports - definitions - repeal. (Repealed)

25.5-1-203. Prescription drug information and technical assistance program - expansion. The state department may expand the prescription drug information and technical assistance program created in section 25.5-5-507 to include persons receiving drug benefits pursuant to any program that is administered by the state department.

25.5-1-204. Advisory committee to oversee the all-payer health claims database - legislative declaration - creation - members - duties - creation of all-payer health claims database - rules. (1) The general assembly hereby finds and declares that an advisory committee for the all-payer health claims database would support the database in its established mission of facilitating the reporting of health care and health quality data that results in transparent and public reporting of safety, quality, cost, and efficiency information; and analysis of health care spending and utilization patterns for purposes that improve the population's health, improve the care experience, and control costs.

(2) (a) No later than August 1, 2013, the executive director shall appoint an advisory committee to oversee the Colorado all-payer health claims database. The advisory committee shall include the following members:

(I) A member of academia with experience in health care data and cost efficiency research;

(II) A representative of:

(A) A statewide association of hospitals;

(B) An integrated multi-specialty organization;

(C) Physicians and surgeons;

(D) An organization that processes insurance claims or certain aspects of employee benefit plans for a separate entity;

(E) A nonprofit organization that demonstrates experience working with employers to enhance value and affordability in health insurance;

(F) Dental insurers;

(G) Pharmacists or an affiliate society;

(H) Pharmacy benefit managers;

(I) A statewide association of ambulatory surgical centers;

(III) A representative, who is not a supplier or broker of health insurance, of:

(A) Small employers that purchase group health insurance for employees;

(B) Large employers that purchase health insurance for employees;

(C) Self-insured employers;

(IV) A representative from a community mental health center who has experience in behavioral health data collection;

(V) Three representatives with a demonstrated record of advocating health care issues on behalf of consumers;

(VI) Two representatives of health insurers, one who represents nonprofit insurers and one who represents for-profit insurers;

(VII) Two representatives of nonprofit organizations that facilitate health information exchange to improve health care for all Coloradans;

(VIII) The executive director or his or her designee, serving as an ex officio member;

(IX) The commissioner of insurance or his or her designee, serving as an ex officio member;

(X) A representative of the department of personnel and administration, serving as an ex officio member;

(XI) The director of the office of information and technology or his or her designee, serving as an ex officio member; and

(XII) Two members of the general assembly, one appointed by the majority leader of the senate and one appointed by the majority leader of the house of representatives; except that, if the majority leaders are from the same political party, the minority leader of the house of representatives shall appoint the second member. The two members of the general assembly shall serve as ex officio members.

(b) The advisory committee shall make recommendations to the executive director and the Colorado all-payer health claims database administrator related to the Colorado all-payer health claims database. The recommendations include the following:

(I) Procedures for the collection, retention, use, and disclosure of data from the Colorado all-payer health claims database, including procedures and safeguards to protect the privacy, integrity, confidentiality, and availability of any data;

(II) Guidelines for charging for custom reports from the Colorado all-payer health claims database;

(III) Procedures to ensure compliance with the "Health Insurance Portability and Accountability Act of 1996", Pub.L. 104-191, as amended, and implementing federal regulations;

(IV) Procedures to ensure compliance with other state and federal privacy laws; and

(V) Procedures for data confidentiality and data disposal if the Colorado all-payer health claims database ceases to exist.

(3) (a) The administrator shall prepare and file annual reports to the legislature by March 1 of each year. The annual report must contain:

(I) The uses of the data in the all-payer health claims database;

(II) Public studies produced by the administrator;

(III) The cost of administering the Colorado all-payer health claims database, the sources of the funding, and the total revenue taken in by the database;

(IV) The recipients of the data, the purposes for the data requests, and whether a fee was charged for the data;

(V) A fee schedule displaying the fees for providing custom data reports from the Colorado all-payer health claims database.

(b) The executive director shall require an evaluation of the Colorado all-payer health claims database initiative every five years beginning in 2018, to ensure that the database accomplishes the goals of this section. The report must contain metrics that document and demonstrate the achievements or challenges of the program goals.

(4) The administrator shall seek funding for the creation of the all-payer health claims database and develop a plan for the financial stability of the database. On or before March 1, 2011, the administrator shall report to the governor and the general assembly on the status of the funding effort and on the status of the recommendations of the advisory committee. The report shall include the final data elements recommended by the advisory committee, the final provisions contemplated to comply with the "Health Insurance Portability and Accountability Act of 1996", Pub.L. 104-191, as amended, and any other final recommendations that are ready at the time of the report. If sufficient funding is received through gifts, grants, and donations on or before January 1, 2012, as determined by the executive director, the administrator shall, in consultation with the advisory committee, create the Colorado all-payer claims database. The Colorado all-payer claims database shall be operational no later than January 1, 2013.

(5) If sufficient funding is received, the executive director shall direct the administrator to create the database and the administrator shall:

(a) Determine the data to be collected from payers and the method of collection, including mandatory and voluntary reporting of health care and health quality data. If the administrator requires mandatory reporting, CoverColorado, created in part 5 of article 8 of title 10, C.R.S., shall be included in the mandatory reporting requirements.

Editor's note: This version of paragraph (a) is effective until March 31, 2015.

(a) Determine the data to be collected from payers and the method of collection, including mandatory and voluntary reporting of health care and health quality data;

Editor's note: This version of paragraph (a) is effective March 31, 2015.

(b) Seek to establish agreements for voluntary reporting of health care claims data from health care payers that are not subject to mandatory reporting requirements in order to ensure availability of the most comprehensive and systemwide data on health care costs and quality;

(c) Seek to establish agreements or requests with the federal centers for medicare and medicaid services to obtain medicare health claims data;

(d) Determine the measures necessary to implement the reporting requirements in a manner that is cost-effective and reasonable for data sources and timely, relevant, and reliable for consumers, public and private purchasers, providers, and policymakers;

(e) Determine the reports and data to be made available to the public with recommendations from the advisory committee in order to accomplish the purposes of this section, including conducting studies and reporting the results of the studies;

(f) Collect, aggregate, distribute, and publicly report performance data on quality, health outcomes, health disparities, cost, utilization, and pricing in a manner accessible for consumers, public and private purchasers, providers, and policymakers;

(g) Protect patient privacy in compliance with state and federal medical privacy laws while preserving the ability to analyze data and share with providers and payers to ensure accuracy prior to the public release of information;

(h) Report to the governor and the general assembly on or before March 1 of each year on the status of implementing the database and any recommendations for statutory or regulatory changes, with input from the advisory committee or its successor governance entity, that would advance the purposes of this section;

(i) Provide leadership and coordination of public and private health care quality and performance measurements to ensure efficiency, cost-effectiveness, transparency, and informed choice by consumers and public and private purchasers.

(6) The administrator, with input from the advisory committee:

(a) Shall incorporate and utilize publicly available data other than administrative claims data if necessary to measure and analyze a significant health care quality, safety, or cost issue that cannot be adequately measured with administrative claims data alone;

(b) Shall require payer data sources to submit data necessary to implement the all-payer claims database;

(c) Shall determine the data elements to be collected, the reporting formats for data submitted, and the use and reporting of any data submitted. Data collection shall align with national, regional, and other uniform all-payer claims databases' standards where possible.

(d) May audit the accuracy of all data submitted;

(e) May contract with third parties to collect and process the health care data collected pursuant to this section. The contract shall prohibit the collection of unencrypted social security numbers and the use of the data for any purpose other than those specifically authorized by the contract. The contract shall require the third party to transmit the data collected and processed under the contract to the administrator or other designated entity.

(f) May share data regionally or help develop a multi-state effort if recommended by the advisory committee.

(7) The all-payer health claims database shall:

(a) Be available to the public when disclosed in a form and manner that ensures the privacy and security of personal health information as required by state and federal law, as a resource to insurers, consumers, employers, providers, purchasers of health care, and state agencies to allow for continuous review of health care utilization, expenditures, and quality and safety performance in Colorado;

(b) Be available to state agencies and private entities in Colorado engaged in efforts to improve health care, subject to rules promulgated by the executive director;

(c) Be presented to allow for comparisons of geographic, demographic, and economic factors and institutional size;

(d) Present data in a consumer-friendly manner.

(8) The collection, storage, and release of health care data and other information pursuant to this section is subject to the federal "Health Insurance Portability and Accountability Act of 1996", Pub.L. 104-191, as amended.

(9) The executive director shall promulgate rules as necessary to implement this section, which rules shall include the assessment of a fine for a payer required to submit data that does not comply with this section. Any fines collected shall be deposited in the all-payer health claims database cash fund, which is hereby created in the state treasury. The moneys in the fund shall be appropriated to the department of health care policy and financing for the purpose of maintaining the all-payer health claims database. The moneys in the fund shall remain in the fund and not revert to the general fund or any other fund at the end of any fiscal year.

(10) Repealed.

(11) If at any time, there is not sufficient funding to finance the ongoing operations of the database, the database shall cease operating and the advisory committee and administrator shall no longer have the duty to carry out the functions required pursuant to this section. If the database ceases to operate, the data submitted shall be destroyed or returned to its original source.

25.5-1-205. Providing for the efficient provision of health care through state-supervised cooperative action - rules. (1) Cooperation among health care payors, including both private sector entities and federal and state-administered health care programs, has the potential to eliminate needless and costly complexity in the administration of the programs and to benefit patients, payors, and the government. Further, alignment of financial incentives among private and public entities may accelerate and reinforce improvements in health care quality and patient outcomes.

(2) The executive director shall facilitate departmental oversight of collaboration among providers, medicaid clients and advocates, and payors that is designed to improve health outcomes and patient satisfaction and support the financial sustainability of the

medicaid program.

(3) The executive director may promulgate rules relating to the collaborative process set forth in this section.

PART 3

MEDICAL SERVICES BOARD

25.5-1-301. Medical services board - creation. (1) There is hereby created in the state department a medical services board, referred to in this part 3 as the "board", which shall consist of eleven members appointed by the governor with the consent of the senate. The governor shall appoint persons to the board who have knowledge of medical assistance programs, and one or more of the appointments may include a person or persons who have received services through programs administered by the department within two years of the date of appointment. No more than six members of the board shall be members of the same political party. Of the eleven members appointed to the board, at least one shall be appointed from each congressional district. In making appointments to the board, the governor shall include representation by at least one member who is a person with a disability, as defined in section 24-45.5-102 (2), C.R.S., a family member of a person with a disability, or a member of an advocacy group for persons with disabilities, provided that the other requirements of this subsection (1) are met.

(2) Members shall serve at the pleasure of the governor for a term of four years; except that, of the members first appointed, three shall serve for a term of two years and three shall serve for a term of three years. On July 1, 2001, the governor shall appoint one member from the private sector to the board who shall have experience with the delivery of health care, who shall be appointed for a term of two years, and one member who shall have experience or expertise in caring for medically underserved children, who shall be appointed for a term of three years.

(3) Members shall receive no compensation but shall be reimbursed for reasonable and necessary actual expenses incurred in the performance of their official duties as members of the board.

(4) Vacancies on the board shall be filled by appointment of the governor for the remainder of any unexpired term.

25.5-1-302. Medical services board - organization. (1) The board shall elect from its members a president, a vice-president, and such other board officers as it shall determine. All board officers shall hold their offices at the pleasure of the board.

(2) Regular meetings of the board shall be held not less than once every three months at such times as may be fixed by resolution of the board. All meetings of the board, in every suit and proceeding, shall be considered to have been duly called and regularly held and all orders and proceedings of the board to have been authorized, unless the contrary is proven.

(3) The board shall adopt, and at any time may amend, bylaws in relation to its meetings and the transaction of its business. A majority shall constitute a quorum of the board. The vote of a majority of a quorum of the board shall constitute the action of the board. The board shall act only by resolution adopted at a duly called meeting of the board, and no individual of the board shall exercise any individual administrative authority with respect to the department.

25.5-1-303. Powers and duties of the board - scope of authority - rules. (1) The board shall have the authority set forth in subsection (3) of this section over the following programs administered by the state department:

(a) The "Colorado Medical Assistance Act", as specified in articles 4, 5, and 6 of this title;

(b) The "Colorado indigent care program", as specified in part 1 of article 3 of this title;

(c) Repealed.

(d) The "Children's Basic Health Plan Act", as specified in article 8 of this title;

(e) The old age pension health and medical care program, as specified in section 25.5-2-101;

(f) Programs, services, and supports for persons with intellectual and developmental disabilities, as specified in article 10 of this title.

Editor's note: Paragraph (f) is effective March 1, 2014.

(2) Nothing in this section shall be construed to affect any specific statutory provision granting rule-making authority to the board in relation to a specific program.

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

(a) The implementation of legislative and departmental policies and procedures for such programs; except that no rules shall be promulgated for any policy or procedure which governs the administration of the state department as specified in section 25.5-1-108 (1);

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

(c) The establishment of the type of benefits that a recipient of services may

obtain if eligibility requirements are met, subject to the authorization, requirements, and availability of such benefits;

(d) The requirements, obligations, and rights of clients and recipients;

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

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

(g) The establishment of a procedure to resolve disputes that may arise between providers and between the state department and providers.

(4) At the request of the executive director, the board shall advise the executive director as to any proposed policies or rules governing programs administered by the state department that are not set forth in subsection (1) of this section.

(5) The board shall have no authority over the revenue of the state department.

(6) All rules and orders of the department of human services in connection with the old age pension health and medical care program shall continue to be effective until revised, amended, repealed, or nullified pursuant to law.

(7) The rules issued by the state board shall be binding upon the county departments. At any public hearing relating to a proposed rule-making, interested persons shall have the right to present their data, views, or arguments orally. Proposed rules of the state board shall be subject to the provisions of section 24-4-103, C.R.S.

(8) To the extent that rules are promulgated by the state board of human services for programs or providers that receive either medicaid only or both medicaid and nonmedicaid funding, the rules shall be developed in cooperation with the state department and shall not conflict with state statutes or federal statutes or regulations.

(9) The rules and orders of the department of human services and the state board of human services in connection with the programs, services, and supports specified in paragraph (f) of subsection (1) of this section shall continue to be effective until revised, amended, repealed, or nullified pursuant to law.

Editor's note: Subsection (9) is effective March 1, 2014.

25.5-1-304. Repeal of part. (Deleted by amendment)

PART 4

HEALTH CARE COVERAGE COOPERATIVE RULE-MAKING AUTHORITY

25.5-1-401. (Repealed)

PART 5

COOPERATIVE HEALTH CARE AGREEMENTS
INVOLVING HOSPITALS

25.5-1-501 to 25.5-1-516. (Repealed)

ARTICLE 2

State-funded Health and Medical Care

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.

(1) (Deleted by amendment, L. 2011, (SB 11-210), ch. 187, p. 719, § 2, effective July 15, 2012.)

(2) Any moneys remaining in the state old age pension fund after full payment of basic minimum awards to qualified old age pension recipients and after establishment and maintenance of the old age pension stabilization fund in the amount of five million dollars shall 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 mental diseases. The costs of such program, not to exceed ten million dollars in any fiscal year, shall be defrayed from such health and medical care fund, but all moneys available, accrued or accruing, received or receivable, in said health and medical care fund in excess of ten million dollars in any fiscal year shall be transferred to the general fund of the state to be used pursuant to law. Moneys in the old age pension health and medical care fund shall be subject to annual appropriation by the general assembly.

(3) Repealed.

(4) The state department shall utilize the cash system of accounting, as enunciated by the governmental accounting standards board, regardless of the source of revenues involved, for all activities of the state department relating to the financial administration of any nonadministrative expenditure for the health and medical care programs described

in subsection (2) of this section.

**25.5-2-102. Health and medical care program - aid to the needy disabled.
(Repealed)**

PRESCRIPTION DRUGS

ARTICLE 2.5

Colorado Cares
Prescription Drug Program

25.5-2.5-101. Short title. This article shall be known and may be cited as the "Colorado Cares Rx Act".

25.5-2.5-102. Legislative declaration. (1) The general assembly finds that:

(a) Uninsured, underinsured, and older Coloradans pay a disproportionately greater share of their income for prescription drugs. In many cases, current drug prices have the effect of denying residents access to necessary medical care, thereby threatening their health and safety.

(b) Prescription drugs play an increasingly important role in improving or stabilizing a person's health and in reducing overall health care costs;

(c) Additionally, the new medicare prescription drug benefit restricts persons from purchasing insurance in order to fully cover their prescription drug needs. This restriction on a person's ability to purchase adequate coverage may threaten the person's health and safety;

(d) Currently, there is no limit on the amount that a pharmacy may charge for a generic or nonpatented drug, and, although some retail pharmacies are offering some generic and nonpatented drugs at discounted prices, there are no guarantees that the pharmacies will continue to do so.

(2) The general assembly, therefore, declares that it is important to make information available to the public concerning ways to purchase lower-cost generic and nonpatented prescription drugs through the "Colorado Cares Rx Act" in order to protect the health of uninsured, underinsured, and older Coloradans. The general assembly further declares that the state should continue to actively research cost-effective

mechanisms or programs that may provide additional options to address this need in Colorado.

25.5-2.5-103. Lower-cost prescription drugs - information - research - reporting. (1) The state department shall make information available to the public concerning lower-cost prescription drug programs. The information shall include, but need not be limited to:

(a) Ways in which low-income, uninsured persons can obtain lower-cost prescription drugs; and

(b) Contact information concerning programs for lower-cost prescription drugs.

(2) The state department shall research cost-effective programs or mechanisms by which low-income, uninsured persons may purchase lower-cost prescription drugs.

(3) The state department shall report annually to the health and human services committees of the house of representatives and the senate, or any successor committees, concerning the provisions of this article.

25.5-2.5-104. Program - rules - repeal. (Repealed)

25.5-2.5-105. Cash fund. (Repealed)

25.5-2.5-106. Repeal of article. (Repealed)

INDIGENT CARE

ARTICLE 3

Indigent Care

PART 1

COLORADO INDIGENT CARE PROGRAM

25.5-3-101. Short title. This part 1 shall be known and may be cited as the "Colorado Indigent Care Program".

25.5-3-102. Legislative declaration. (1) The general assembly hereby determines, finds, and declares that:

(a) The state has insufficient resources to pay for all medical services for persons who are indigent and must therefore allocate available resources in a manner that will provide treatment of those conditions constituting the most serious threats to the health of such medically indigent persons, as well as increase access to primary medical care to prevent deterioration of the health conditions among medically indigent people; and

(b) Such allocation of resources will require the prioritization of medical services by providers and the coordination of administration and delivery of medical services.

(2) The general assembly further determines, finds, and declares that the eligibility of medically indigent persons to receive medical services rendered under the conditions specified in subsection (1) of this section exists only to the extent of available appropriations, as well as to the extent of the individual provider facility's physical, staff, and financial capabilities. The general assembly also recognizes that the program for the medically indigent is a partial solution to the health care needs of Colorado's medically indigent citizens. Therefore, medically indigent persons accepting medical services from such program shall be subject to the limitations and requirements imposed in this part 1.

25.5-3-103. Definitions. As used in this part 1, unless the context otherwise requires:

(1) "Emergency care" means treatment for conditions of an acute, severe nature which are life, limb, or disability threats requiring immediate attention, where any delay in treatment would, in the judgment of the responsible physician, threaten life or loss of function of a patient or viable fetus.

(2) "Executive director" means the executive director of the state department.

(3) "General provider" means a general hospital, birth center, or community health clinic licensed or certified by the department of public health and environment pursuant to section 25-1.5-103 (1) (a) (I) or (1) (a) (II), C.R.S.; a federally qualified health center, as defined in section 1861 (aa) (4) of the federal "Social Security Act", 42 U.S.C. sec. 1395x (aa) (4); a rural health clinic, as defined in section 1861 (aa) (2) of the federal "Social Security Act", 42 U.S.C. sec. 1395x (aa) (2); a health maintenance organization issued a certificate of authority pursuant to section 10-16-402, C.R.S.; and the health sciences center when acting pursuant to section 25.5-3-108 (5) (a) (I) or (5) (a) (II) (A). For the purposes of the program, "general provider" includes associated physicians.

(4) "Health sciences center" means the schools of medicine, dentistry, nursing, and pharmacy established by the regents of the university of Colorado under section 5 of article VIII of the Colorado constitution.

(5) "Program" means the program for the medically indigent established by

section 25.5-3-104.

(6) "University hospital" means the university hospital operated pursuant to article 21 of title 23, C.R.S.

25.5-3-104. Program for the medically indigent established - eligibility - rules. (1) A program for the medically indigent is hereby established, to commence July 1, 1983, which shall be administered by the state department, to provide payment to providers for the provision of medical services to eligible persons who are medically indigent. The state board may promulgate rules as are necessary for the implementation of this part 1 in accordance with article 4 of title 24, C.R.S.

(2) A client's eligibility to receive discounted services under the program for the medically indigent shall be determined by rule of the state board based on a specified percentage of the federal poverty line, adjusted for family size, which percentage shall not be less than two hundred fifty percent.

25.5-3-105. Eligibility of legal immigrants for services. A legal immigrant who is a resident of the state of Colorado shall be eligible to receive services under this part 1 so long as he or she meets the eligibility requirements. As used in this section, "legal immigrant" has the same meaning as described in section 25.5-4-103 (10). As a condition of eligibility for services under this part 1, a legal immigrant shall agree to refrain from executing an affidavit of support for the purpose of sponsoring an alien on or after July 1, 1997, under rules promulgated by the immigration and naturalization service, or any successor agency, during the pendency of such legal immigrant's receipt of services under this part 1. Nothing in this section shall be construed to affect a legal immigrant's eligibility for services under this part 1 based upon such legal immigrant's responsibilities under an affidavit of support entered into before July 1, 1997.

25.5-3-106. No public funds for abortion - exception - definitions - repeal. (1) It is the purpose of this section to implement the provisions of amendment 3 to article V of the Colorado constitution, adopted by the registered electors of the state of Colorado at the general election November 6, 1984, which prohibits the use of public funds by the state of Colorado or its agencies or political subdivisions to pay or otherwise reimburse, directly or indirectly, any person, agency, or facility for any induced abortion.

(2) If every reasonable effort has been made to preserve the lives of a pregnant woman and her unborn child, then public funds may be used pursuant to this section to pay or reimburse for necessary medical services, not otherwise provided for by law.

(3) (a) Except as provided in paragraph (b) of this subsection (3), any necessary

medical services performed pursuant to this section shall be performed only in a licensed health care facility by a provider who is a licensed physician.

(b) However, such services may be performed in other than a licensed health care facility if, in the medical judgment of the attending physician, the life of the pregnant woman or her unborn child is substantially threatened and a transfer to a licensed health care facility would further endanger the life of the pregnant woman or her unborn child. Such medical services may be performed in other than a licensed health care facility if the medical services are necessitated by a life-endangering circumstance described in subparagraph (II) of paragraph (b) of subsection (6) of this section and if there is no licensed health care facility within a thirty-mile radius of the place where such medical services are performed.

(4) (a) Any physician who renders necessary medical services pursuant to subsection (2) of this section shall report the following information to the state department:

(I) The age of the pregnant woman and the gestational age of the unborn child at the time the necessary medical services were performed;

(II) The necessary medical services which were performed;

(III) The medical condition which necessitated the performance of necessary medical services;

(IV) The date such necessary medical services were performed and the name of the facility in which such services were performed.

(b) The information required to be reported pursuant to paragraph (a) of this subsection (4) shall be compiled by the state department and such compilation shall be an ongoing public record; except that the privacy of the pregnant woman and the attending physician shall be preserved.

(5) For purposes of this section, pregnancy is a medically diagnosable condition.

(6) For the purposes of this section:

(a) (I) "Death" means:

(A) The irreversible cessation of circulatory and respiratory functions; or

(B) The irreversible cessation of all functions of the entire brain, including the brain stem.

(II) A determination of death under this section shall be in accordance with accepted medical standards.

(b) "Life-endangering circumstance" means:

(I) The presence of a medical condition, other than a psychiatric condition, as determined by the attending physician, which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy continues to term;

(II) The presence of a lethal medical condition in the unborn child, as determined by the attending physician and one other physician, which would result in the impending death of the unborn child during the term of pregnancy or at birth; or

(III) The presence of a psychiatric condition which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy continues to term. In such case, unless the pregnant woman has been receiving prolonged psychiatric care, the attending licensed physician shall obtain consultation from a licensed physician specializing in psychiatry confirming the presence of such a psychiatric condition. The attending physician shall report the findings of such consultation to the state department.

(c) "Necessary medical services" means any medical procedures deemed necessary to prevent the death of a pregnant woman or her unborn child due to life-endangering circumstances.

(7) If any provision of this section or application thereof is held invalid, such invalidity shall not affect other provisions or applications of this section which can be given effect without the invalid provision or application and, to this end, provisions of this section are declared severable.

(8) Use of the term "unborn child" in this section is solely for the purposes of facilitating the implementation of section 50 of article V of the state constitution and its use shall not affect any other law or statute nor shall it create any presumptions relating to the legal status of an unborn child or create or affect any distinction between the legal status of an unborn child and the legal status of a fetus.

(9) This section shall be repealed if section 50 of article V of the Colorado constitution is repealed.

25.5-3-107. Report concerning the program. The executive director shall prepare an annual report concerning the status of the medically indigent program to be submitted to the health and human services committees of the senate and the house of representatives, or any successor committees, no later than February 1 of each year. The report shall be prepared following consultation with providers in the program, state department personnel, and other agencies, organizations, or individuals as the executive director deems appropriate in order to obtain comprehensive and objective information about the program.

25.5-3-108. Responsibility of the department of health care policy and financing - provider reimbursement. (1) The state department shall be responsible for:

(a) Execution of such contracts with providers for partial reimbursement of costs for medical services rendered to the medically indigent as the state department shall determine are necessary for the program;

(b) Promulgation of such reasonable rules as are necessary for the program;

(c) Submission of the report required in section 25.5-3-107; and

(d) Application for federal financial participation under the program.

(2) The contracts required by paragraph (a) of subsection (1) of this section shall be negotiated between the state department and the various general providers, as defined in section 25.5-3-103 (3), and shall include contracts with providers to provide tertiary or specialized services. The state department may award such contracts upon a determination that it would not be cost effective nor result in adequate quality of care for such services to be developed by the contract providers, or upon a determination that the contract providers are unable or unwilling to provide such services.

(3) The state department shall establish procedures requiring the provider to provide for proof of indigency to be submitted by the person seeking assistance, but the provider shall be responsible for the determination of eligibility.

(4) The state department shall establish procedures so that the providers of medical services rendered to the medically indigent cover geographic regions of the state.

(5) (a) The responsibilities of providers who provide medical care through the program for the medically indigent are as follows:

(I) Denver health and hospitals, including associated physicians, shall, up to its physical, staff, and financial capabilities as provided for under this program, be the primary providers of medical services to the medically indigent for the city and county of Denver.

(II) (A) University hospital and the physicians and other faculty members of the health sciences center shall, up to their physical, staff, and financial capabilities as provided for under this program, be the primary provider of medical services to the medically indigent for the Denver primary metropolitan statistical area.

(B) University hospital and the physicians and other faculty members of the health sciences center shall be the primary provider of such complex care as is not available or is not contracted for in the remaining areas of the state up to their physical, staff, and financial capabilities as provided for under this program.

(b) Any two or more providers awarded contracts may, with the approval of the state department, redistribute their respective populations and associated funds.

(c) Every provider who provides medical care through the program for the medically indigent shall comply with all procedures established by the state department.

(6) The state department shall establish procedures that allocate funds to providers based on the anticipated utilization of services.

(7) A provider receiving reimbursement pursuant to this section shall transfer a medically indigent patient to another provider only with the prior agreement of the provider.

(8) (a) Every provider receiving reimbursement pursuant to this section shall prioritize for each fiscal year the medical services which it will be able to render, within the limits of the funds which will be made available by the state department.

(b) Such medical services shall be prioritized in the following order:

(I) Emergency care for the full year;

(II) Any additional medical care for those conditions the state department determines to be the most serious threat to the health of medically indigent persons;

(III) Any other additional medical care.

(9) A provider receiving reimbursement pursuant to this section shall not be liable in civil damages for refusing to admit for treatment or for refusing to treat any medically indigent person for a condition which the state department or the provider has determined to be outside of the scope of the program.

(10) (a) A medically indigent person who wishes to be determined eligible for assistance under this part 1 shall comply with the eligibility requirements set by the state department.

(b) A medically indigent person requesting assistance under this part 1 specifically authorizes the state department or provider to:

(I) Use any information required by the eligibility requirements set by the state department for the purpose of verifying eligibility; and

(II) Obtain records pertaining to eligibility from a financial institution, as defined in section 15-15-201 (4), C.R.S., or from any insurance company.

(c) A medically indigent person requesting assistance under this part 1 shall be provided language clearly explaining the provisions of this subsection (10).

(11) With the approval of the state department, any provider awarded a contract may enter into subcontracts or other agreements for services related to the program.

(12) Providers awarded contracts shall not be paid from funds made available for this program up to the extent, if any, of their annual financial obligation under the Hill-Burton act.

(13) When adopting or modifying procedures under this part 1, the state department shall notify each provider, who is contracted to provide medical care through the program for the medically indigent, at least thirty days prior to implementation of a new procedure. The state department shall hold a meeting for all providers at least thirty days prior to the implementation of a new procedure.

(14) The state department shall require any hospital provider who may receive payment under the program to annually submit data relating to the hospital's number of medicaid-eligible in-patient days and the hospital's total in-patient days in a form specified by the state department. The hospital provider shall verify the data to the state department through the program audit procedures required by the state department. The state department shall include this information by hospital in the department's annual budget request to the joint budget committee of the general assembly and in the report required by section 25.5-3-107.

(15) To qualify for the program's payment formula disproportionate share hospital factor, as described in rule by the state board consistent with the provisions of this part 1, a hospital provider's percent of medicaid-eligible in-patient days relative to total in-patient days shall be equal to or exceed one standard deviation above the mean.

(16) After receiving approval by the state department, a community health clinic may utilize moneys received pursuant to this article, and any gifts, grants, and donations, for the development and implementation of demonstration projects that may include but need not be limited to coordination of care and disease management.

(17) Subject to adequate funding made available under section 25.5-4-402.3, the state department shall increase hospital reimbursements up to one hundred percent of hospital costs for providing medical care under the program.

(18) Repealed.

25.5-3-109. Appropriations. The general assembly shall make annual appropriations to the state department to accomplish the purposes of this part 1.

25.5-3-110. Effect of part 1. This part 1 shall not affect the department of human services' responsibilities for the provision of mental health care in accordance with article 66 of title 27, C.R.S., and this part 1 shall not affect any provisions of article 22 of title 23, C.R.S., or any other provisions of law relating to the university of Colorado psychiatric hospital.

25.5-3-111. Penalties. Any person who represents that any medical service is reimbursable or subject to payment under this part 1 when he or she knows that it is not and any person who represents that he or she is eligible for assistance under this part 1 when he or she knows that he or she is not commits a class 2 misdemeanor and shall be punished as provided in section 18-1.3-501, C.R.S.

25.5-3-112. Health care services fund - creation - state plan amendment - primary care special distribution fund. (1) (a) There is hereby created in the state treasury the Colorado health care services fund, referred to in this section as the "fund". The fund shall consist of moneys credited thereto pursuant to this section.

(b) In fiscal year 2005-06, the general assembly shall appropriate fourteen million nine hundred sixty-two thousand four hundred eight dollars from the general fund to the fund. Of the moneys in the general fund exempt account created in section 24-77-103.6 (2), C.R.S., the following amounts shall be appropriated by the general assembly to the fund:

(I) In fiscal year 2007-08, fifteen million dollars; and

(II) In fiscal year 2008-09, twelve million nine hundred eighteen thousand seven hundred fifty dollars.

(III) (Deleted by amendment, L. 2010, (HB 10-1321), ch. 48, p. 179, § 1, effective March 29, 2010.)

(b.5) In fiscal year 2009-10, the general assembly shall appropriate ten million three hundred ninety thousand dollars from the general fund to the fund.

(b.6) In fiscal year 2011-12, the treasurer shall transfer one million dollars from the general fund to the fund.

(c) All moneys appropriated to the fund shall be used as provided in this section and shall not be deposited in or transferred to the general fund of this state or to any other fund. Notwithstanding any provision of section 24-36-114, C.R.S., to the contrary, all interest derived from the deposit and investment of moneys in the fund shall be credited to the fund.

(1.5) Notwithstanding any provision of subsection (1) of this section to the contrary, on April 20, 2009, the state treasurer shall deduct five hundred thousand dollars from the fund and transfer such sum to the general fund.

(2) In fiscal year 2006-07, and each of the two fiscal years thereafter, notwithstanding the requirements of section 25.5-3-108 (8) (b), the moneys deposited into the fund shall be appropriated as follows:

(a) Of the moneys appropriated pursuant to this subsection (2), eighteen percent of the moneys annually appropriated shall be to Denver health and hospitals as the community health clinic provider for the city and county of Denver.

(b) (I) For fiscal year 2006-07, eighty-two percent of the moneys remaining after the appropriation pursuant to paragraph (a) of this subsection (2) shall be appropriated to community health clinics to provide primary care services pursuant to this article.

(II) For fiscal year 2006-07, eighteen percent of the moneys remaining after the appropriation pursuant to paragraph (a) of this subsection (2) shall be appropriated to primary care clinics operated by a licensed or certified health care facility to provide primary care services pursuant to this article.

(III) For fiscal years 2007-08 and 2008-09, the allocation of the moneys remaining after the appropriation pursuant to paragraph (a) of this subsection (2) shall be determined based on prior utilization as specified in rule by the state board.

(2.5) In fiscal year 2009-10, notwithstanding the requirements of section 25.5-3-108 (8) (b), the moneys deposited into the fund shall be appropriated as follows:

(a) Twenty percent of the moneys shall be appropriated to the state department for distribution to Denver health and hospitals as the community health clinic provider for the city and county of Denver;

(b) Eighty percent of the moneys shall be appropriated to the state department for distribution to community health clinics based upon prior utilizations as determined by the state department to mitigate reductions the clinics experience due to reductions in moneys available from the primary care fund created pursuant to section 24-22-117 (2) (b), C.R.S.

(2.7) In the 2010-11 fiscal year, notwithstanding the requirements of section 25.5-3-108 (8) (b), the moneys deposited into the fund shall be appropriated to the state department for distribution to Denver health and hospitals, as the community health clinic for the city and county of Denver, and to community health clinics. The state department shall develop a distribution formula specifying the distributions based upon prior utilizations and, to the extent possible, mitigation of the reductions in funding that the clinics experience due to reductions in moneys available from the primary care fund established pursuant to section 24-22-117 (2) (b), C.R.S.

(2.8) In the 2011-12 fiscal year, notwithstanding the requirements of section 25.5-3-108 (8) (b), the moneys deposited into the fund shall be appropriated to the state department for distribution to Denver health and hospitals, as the community health clinic for the city and county of Denver, to community health clinics, and to federally qualified health centers. The state department shall develop a distribution formula specifying the distributions based upon prior utilizations and, to the extent possible, mitigation of the reductions in funding that the clinics experience due to reductions in moneys available from the primary care fund established pursuant to section 24-22-117 (2) (b), C.R.S.

(3) (a) The state department shall submit a state plan amendment for federal financial participation for moneys appropriated to primary care clinics operated by a licensed or certified health care facility. Upon approval of the state plan amendment, the state department is authorized to receive and expend all available federal moneys without a corresponding reduction in spending authority from the fund.

(b) To the extent possible under federal law, the state department shall pursue available federal financial participation for moneys appropriated to community health clinics.

(4) Repealed.

PART 2

COMPREHENSIVE PRIMARY AND PREVENTIVE CARE GRANT PROGRAM

25.5-3-201. Short title. (Repealed)

25.5-3-202. Legislative declaration. (Repealed)

25.5-3-203. Definitions. (Repealed)

25.5-3-204. Comprehensive primary and preventive care grant program - creation. (Repealed)

25.5-3-205. Grant-making process. (Repealed)

25.5-3-206. Reports. (Repealed)

25.5-3-207. Program funding - comprehensive primary and preventive care fund - creation - repeal. (Repealed)

PART 3

COMPREHENSIVE PRIMARY CARE SERVICES

25.5-3-301. Definitions. As used in this part 3, unless the context otherwise requires:

(1) "Comprehensive primary care" means the basic, entry-level health care provided by health care practitioners or non-physician health care practitioners that is generally provided in an outpatient setting. "Comprehensive primary care", at a minimum, includes providing or arranging for the provision of the following services on a year-round basis: Primary health care; maternity care, including prenatal care; preventive, developmental, and diagnostic services for infants and children; adult preventive services; diagnostic laboratory and radiology services; emergency care for minor trauma; pharmaceutical services; and coordination and follow-up for hospital care. "Comprehensive primary care" may also include optional services based on a patient's needs. For the purposes of this subsection (1) and subsection (2) of this section, "arranging for the provision" means demonstrating established referral relationships with health care providers for any of the comprehensive primary care services not directly provided by an entity. An entity in a rural area may be exempt from this requirement if it can demonstrate that there are no providers in the community to provide one or more of the comprehensive primary care services.

(2) "Qualified provider" means an entity that provides comprehensive primary care services and that:

(a) Accepts all patients regardless of their ability to pay and uses a sliding fee schedule for payments or that provides comprehensive primary care services free of charge;

(b) Serves a designated medically underserved area or population, as provided in section 330(b) of the federal "Public Health Service Act", 42 U.S.C. sec. 254b, or demonstrates to the state department that the entity serves a population or area that lacks adequate health care services for low-income, uninsured persons;

(c) Has a demonstrated track record of providing cost-effective care;

(d) Provides or arranges for the provision of comprehensive primary care services to persons of all ages; and

(e) Completes initial screening for eligibility for the state medical assistance program, the children's basic health plan, and any other relevant government health care program and referral to the appropriate agency for eligibility determination.

(3) "Uninsured or medically indigent patient" means a patient receiving services from a qualified provider:

(a) Whose yearly family income is below two hundred percent of the federal poverty line; and

(b) Who is not eligible for medicaid, medicare, or any other type of governmental reimbursement for health care costs; and

(c) Who is not receiving third-party payments.

25.5-3-302. Annual allocation - primary care services - qualified provider - rules. (1) The state department shall annually allocate the moneys appropriated by the general assembly to the primary care fund created in section 24-22-117 (2) (b), C.R.S., to all eligible qualified providers in the state who comply with the requirements of subsection (2) of this section. The state department shall allocate the moneys in amounts proportionate to the number of uninsured or medically indigent patients served by the qualified provider. For a qualified provider to be eligible for an allocation pursuant to this section, the qualified provider shall meet either of the following criteria:

(a) The qualified provider is a community health center, as defined in section 330 of the federal "Public Health Service Act", 42 U.S.C. sec. 254b; or

(b) At least fifty percent of the patients served by the qualified provider are uninsured or medically indigent patients, or patients who are enrolled in the medical assistance program, articles 4, 5, and 6 of this title, or the children's basic health plan, article 8 of this title, or any combination thereof.

(2) A qualified provider shall annually submit to the state department information sufficient to establish the provider's eligibility status. A qualified provider, except for a provider specified in paragraph (a) of subsection (1) of this section, shall provide an annual report that includes the total number of patients served, the number of uninsured or medically indigent patients served, and the number of patients served who are enrolled in the medical assistance program, articles 4, 5, and 6 of this title, or the children's basic health plan, article 8 of this title. A community health center specified in paragraph (a) of subsection (1) of this section shall annually provide to the state department the number of

uninsured or medically indigent patients served. Each eligible qualified provider shall annually develop and submit to the state department documentation regarding the quality assurance program in place at the provider's facility to ensure that quality comprehensive primary care services are being provided. All qualified providers shall submit to the state department the information required under this section, as specified in rule by the state board. The data regarding the number of patients served shall be verified by an outside entity. For purposes of this part 3, the number of patients served is the number of unduplicated users of health care services and is not the number of visits by a patient.

(3) The state department shall make annual direct allocations of the total amount of money annually appropriated by the general assembly to the primary care fund pursuant to section 24-22-117 (2) (b), C.R.S., minus three percent for the administrative costs of the program, to all eligible qualified providers. An eligible qualified provider's allocation shall be based on the number of uninsured or medically indigent patients served by the provider in proportion to the total number of uninsured or medically indigent patients served by all eligible qualified providers in the previous calendar year. The state department shall establish a schedule for allocating the moneys in the primary care fund for eligible qualified providers. The disbursement of moneys in the primary care fund to eligible qualified providers under this part 3 are exempt from the provisions of the "Procurement Code", articles 101 to 112 of title 24, C.R.S.

(4) The state board shall adopt any rules necessary for the administration and implementation of this part 3.

25.5-3-303. Consultation. At least annually, the state department shall consult with representatives of federally qualified health centers, school-based health centers, family residency directors, certified rural health clinics, other qualified providers, and consumer advocates regarding the implementation and administration of the allocation of moneys to qualified providers under this part 3.

COLORADO MEDICAL ASSISTANCE ACT

ARTICLE 4

Colorado Medical Assistance Act - General Medical Assistance

PART 1

GENERAL PROVISIONS

25.5-4-101. Short title. This article and articles 5 and 6 of this title shall be known and may be cited as the "Colorado Medical Assistance Act".

25.5-4-102. Legislative declaration. It is the purpose of the "Colorado Medical Assistance Act" to promote the public health and welfare of the people of Colorado by providing, in cooperation with the federal government, medical and remedial care and services for individuals and families whose income and resources are insufficient to meet the costs of such necessary services and to assist such individuals and families to attain or retain their capabilities for independence and self-care, as contemplated by the provisions of Title XIX of the social security act. The state of Colorado and its various departments, agencies, and political subdivisions are authorized to promote and achieve these ends by any appropriate lawful means, through cooperation with and the utilization of available resources of the federal government and private individuals and organizations.

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

(1) "1931 medicaid recipient" means any person who is eligible for medicaid as provided in section 25.5-5-101 (1) (a), 25.5-5-201 (1) (a), or 25.5-5-201 (1) (h) and refers to section 1931 of Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396u-1.

(2) "Applicant" means any person who has applied for benefits under this article and articles 5 and 6 of this title.

(3) "Case management services" means services provided by community centered boards, as defined by section 27-10.5-102 (3), C.R.S., and community mental health centers and community mental health clinics, as defined by section 27-66-101, C.R.S., to assist developmentally disabled persons, as defined by section 27-10.5-102 (11), C.R.S., and persons with mental illness, as defined by section 27-65-102 (14), C.R.S., by case management agencies, as defined in section 25.5-6-303 (5), providing services, as defined in sections 25.5-6-104 (2) (b) and 25.5-6-303 (6), to elderly, blind, and disabled persons and long-term care clients, in gaining access to needed medical, social, educational, and other services.

Editor's note: This version of subsection (3) is effective until March 1, 2014.

(3) "Case management services" means services provided by community-centered boards, as defined by section 25.5-10-202, and community mental health centers and community mental health clinics, as defined by section 27-66-101, C.R.S., to assist persons with intellectual and developmental disabilities, as defined by section 25.5-10-202, and persons with mental illness, as defined by section 27-65-102 (14), C.R.S., by

case management agencies, as defined in section 25.5-6-303 (5), providing services, as defined in sections 25.5-6-104 (2) (b) and 25.5-6-303 (6), to persons who are elderly, blind, and disabled and long-term care clients, in gaining access to needed medical, social, educational, and other services.

Editor's note: This version of subsection (3) is effective March 1, 2014.

(4) "Categorically needy" means those persons who are eligible for medical assistance under this article and articles 5 and 6 of this title due to their eligibility for one or more of the federal categories of public assistance. A person may be categorically needy and eligible for medical assistance under mandatory provisions as provided under section 25.5-5-101 or may be categorically needy under optional provisions as provided under section 25.5-5-201.

(5) "Clinic services" means those services as defined in section 25.5-5-301.

(6) "Essential person" means a person who meets the requirements of section 26-2-103 (5), C.R.S.

(7) "Home health services" is synonymous with "home health care" and includes the following services provided to an eligible person in his place of residence, through a certified home health agency, pursuant to a home health plan of care:

- (a) Nursing services;
- (b) Home health aide services;
- (c) Provision of medical supplies, equipment, and appliances suitable for use in the home;
- (d) Physical therapy, occupational therapy, or speech and hearing therapy.

(8) "Hospice care" means services provided by a public agency or private organization, or any subdivision thereof, which entity shall be known as a hospice and shall be primarily engaged in providing care to an individual for whom a certified medical prognosis has been made indicating a life expectancy of six months or less and who has elected to receive such care in lieu of other medical benefits available under this article and articles 5 and 6 of this title.

(9) "Intermediate nursing facility for the mentally retarded" means a tax-supported, state-administered intermediate nursing facility, or a distinct part of such facility, which meets the state nursing home licensing standards set forth in section 25-1.5-103 (1) (a) (I), C.R.S., and the requirements in 42 U.S.C. sec. 1396d and which:

Editor's note: This version of the introductory portion to subsection (9) is effective until March 1, 2014.

(9) "Intermediate nursing facility for persons with intellectual and developmental disabilities" means a tax-supported, state-administered intermediate nursing facility, or a

distinct part of such facility, which meets the state nursing home licensing standards set forth in section 25-1.5-103 (1) (a) (I), C.R.S., and the requirements in 42 U.S.C. sec. 1396d and which:

Editor's note: This version of the introductory portion to subsection (9) is effective March 1, 2014.

(a) Is maintained primarily to provide health-related care on a regular basis for the mentally retarded or for persons with developmental disabilities, as defined in section 27-10.5-102 (11), C.R.S., who do not require the degree of care and treatment which a hospital or skilled nursing facility can provide but who, because of their mental or physical condition, require care and services above the level of room and board, which can be made available only through institutional facilities; and

Editor's note: This version of paragraph (a) is effective until March 1, 2014.

(a) Is maintained primarily to provide health-related care on a regular basis for persons with intellectual and developmental disabilities, as defined in section 27-10.5-102 (11), C.R.S., and section 25.5-10-202, C.R.S., who do not require the degree of services and supports that a hospital or skilled nursing facility can provide but who, because of their mental or physical condition, require care and services above the level of room and board, which can be made available only through institutional facilities; and

Editor's note: This version of paragraph (a) is effective March 1, 2014.

(b) May provide care which includes but is not limited to moderate assistance or therapy functions; occasional direction, supervision, or therapy; moderate assistance or therapy for loss of mobility; routine, nonskilled nursing services; and monitoring of the drug regimen.

(10) "Legal immigrant" means an individual who is not a citizen or national of the United States and who was lawfully admitted to the United States by the immigration and naturalization service, or any successor agency, as an actual or prospective permanent resident or whose extended physical presence in the United States is known to and allowed by the immigration and naturalization service, or any successor agency.

(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 of medical assistance.

(12) "Managed care system" means a system for providing health care services which integrates both the delivery and the financing of health care services in an attempt

to provide access to medical services while containing the cost and use of medical care.

(13) "Medical assistance" means payment on behalf of recipients eligible for and enrolled in the program established in articles 4, 5, and 6 of this title, which is funded through Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396u-1, to enrolled providers under the state medical assistance program of medical care, services, goods, and devices rendered or provided to recipients under this article and articles 5 and 6 of this title, and other related payments, pursuant to this article and articles 5 and 6 of this title and the rules of the state department.

(14) "Nursing facility" means a facility, or a distinct part of a facility, which meets the state nursing home licensing standards in section 25-1.5-103 (1) (a) (I), C.R.S., is maintained primarily for the care and treatment of inpatients under the direction of a physician, and meets the requirements in 42 U.S.C. sec. 1396r for certification as a qualified provider of nursing facility services. The patients in such a facility require supportive, therapeutic, or compensating services and the availability of a licensed nurse for observation or treatment on a twenty-four-hour basis. Nursing care may include but is not limited to terminal care; extensive assistance or therapy in the activities of daily living; continual direction, supervision, or therapy; extensive assistance or therapy for loss of mobility; nursing assessment and services which involve assessment of the total needs of the patient, planning of patient care, and observing, monitoring, and recording the patient's response to treatment; and monitoring, observing, and evaluating the drug regimen. "Nursing facility" includes private, nonprofit, or proprietary intermediate nursing facilities for the mentally retarded or developmentally disabled.

(15) "Overpayment" means the amount paid by an agency administering the medical assistance program to an enrolled provider under the state medical assistance program participating in the program, which amount is in excess of the amount that is allowable for services furnished and which is required by Title XIX of the social security act to be refunded to the appropriate medicaid agencies.

(16) "Patient personal needs trust fund" means any fund or account established by the nursing care facility or intermediate care facility or its agents, employees, or designees to manage the personal needs funds of the facility's patients.

(17) "Personal needs funds" means moneys received by any person admitted to a nursing care facility or intermediate care facility, which moneys are received by said person to purchase necessary clothing, incidentals, or other personal needs items which are not reimbursed by any federal or state program, or items of value, which moneys or items of value are in any way surrendered to the management or control of said facility, its agents, employees, or designees.

(18) "Pilot program", as used in section 25.5-5-319, means the family planning pilot program established in section 25.5-5-319, which is carried out by all medicaid providers who provide family planning services and which shall be repealed, effective July 1 five years after the issuance of the federal waiver or July 1 in the year in which the

waiver is terminated, whichever occurs first.

(19) (a) "Provider" means any person, public or private institution, agency, or business concern providing medical care, services, or goods authorized under this article and articles 5 and 6 of this title and holding, where applicable, a current valid license or certificate to provide such services or to dispense such goods and enrolled under the state medical assistance program. These services must be provided and goods must be dispensed only if performed, referred, or ordered by a doctor of medicine or a doctor of osteopathy. Services of dentists, podiatrists, and optometrists or services provided by a school district under section 25.5-5-318 need not be referred or ordered by a doctor of medicine or a doctor of osteopathy.

(b) "Provider" includes a laboratory certified under the federal "Clinical Laboratories Improvement Act of 1967", as amended, 42 U.S.C. sec. 263a, to perform high complexity testing.

(19.5) "Psychiatric residential treatment facility" means a facility that is licensed as a residential child care facility, as defined in section 26-6-102 (8), C.R.S., that is not a hospital, and that provides inpatient psychiatric services for individuals who are less than twenty-one years of age under the direction of a physician licensed pursuant to article 36 of title 12, C.R.S., and that meets any other requirement established in rule by the state board.

(20) "Qualified alien" shall have the meaning ascribed to that term in section 431 (b) of the federal "Personal Responsibility and Work Opportunity Reconciliation Act of 1996", Public Law 104-193, as amended.

(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 or his heirs, assigns, or legal representatives as the result of any liability of a third party.

(23) "Rehabilitative services" means any medical or remedial services recommended by a physician which may reduce physical or mental disability and which may improve functional level.

(24) "Resident" means any individual who is living, other than temporarily, within the state. "Resident" includes any unemancipated child whose parent, or other person entitled to custody, lives within the state. The state board shall adopt rules for making this determination. Temporary absences from the state shall not cause an individual to lose his status as a resident of this state.

(25) "Social security act" means the federal "Social Security Act" and amendments thereto.

(25.5) "State university teaching hospital" means a hospital licensed or certified pursuant to section 25-1.5-103 (1) (a), C.R.S.:

(a) That provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education as defined in section 23-18-102 (10), C.R.S.; and

(b) In which more than fifty percent of its credentialed physicians are members of the faculty at a state institution of higher education as defined in section 23-18-102 (10), C.R.S.

(26) "Third party" means an individual, institution, corporation, or public or private agency which 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 of medical assistance.

(27) "Title XIX" means Title XIX of the social security act, as amended, administered by the federal department of health and human services, or any successor agency, and includes amendments thereto and other federal social security laws replacing said title, in whole or in part.

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

25.5-4-104. Program of medical assistance - 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 program in accordance with Title XIX and this article and articles 5 and 6 of this title. Such program shall not be required to furnish recipients under sixty-five years of age the benefits that are provided to recipients sixty-five years of age and over under Title XVIII of the social security act; but said program shall otherwise be uniform to the extent required by Title XIX of the social security act.

(2) The state department 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 additional investigation as it deems necessary and shall, after giving the county department an opportunity to rebut any 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, make such decision as to the granting of medical benefits and the amount thereof as in its opinion is justifiable pursuant to the provisions of this article and articles 5 and 6 of this title and the rules of the state department. Applicants or recipients affected by such decisions of the state department, upon request, shall be given reasonable notice and opportunity for a fair hearing by the state department.

25.5-4-105. Federal requirements under Title XIX. Nothing in this article or articles 5 and 6 of this title shall prevent the state department from complying with federal requirements for a program of medical assistance in order for the state of Colorado to qualify for federal funds under Title XIX of the social security act and to maintain a program within the limits of available appropriations.

25.5-4-106. Cooperation with federal government - grants-in-aid - cooperation with the department of human services in delivery of services. (1) The state department shall be the sole state agency for administering the state plans for health and medical assistance pursuant to this title, and any other state plan relating to medical assistance that requires state action which is not specifically the responsibility of some other state department, division, section, board, commission, or committee under the provisions of federal or state law.

(2) (a) The state department may accept on behalf of the state of Colorado the provisions and benefits of acts of congress designed to provide funds or other property for particular medical assistance within the state, which funds or other property are designated for such purposes within the function of the state department, and may accept on behalf of the state any offers which have been or may from time to time be made of funds or other property by any persons, agencies, or entities for particular medical assistance activities within the state, which funds or other property are designated for such purposes within the function of the state department; but, unless otherwise expressly provided by law, such acceptance shall not be manifested unless and until the state department has recommended such acceptance to and received the written approval of the governor and the attorney general. Such approval shall authorize the acceptance of the funds or property in accordance with the restrictions and conditions for the purpose for which funds or property are intended.

(b) The state treasurer is designated as ex officio custodian of all medical assistance funds received by the state from the federal government and from any other source, if the approval provided for in paragraph (a) of this subsection (2) has been obtained.

(c) The state treasurer shall hold each such fund separate and distinct from state funds and is authorized to make disbursements from such funds for the designated purpose or for administrative costs, which may be provided in such grants upon warrants issued by the state controller upon the voucher of the state department.

(3) The state department shall cooperate with the federal department of health and human services and other federal agencies in any reasonable manner, in conformity with the laws of this state, which may be necessary to qualify for federal financial participation, including the preparation of state plans, the making of reports in such form and containing such information as any federal agency may from time to time require, and

the compliance with such provisions as the federal government may from time to time find necessary to assure the correctness and verification of the reports.

(4) The rules of the state department may include provisions to accommodate requirements of contracts entered into between the state department and the federal department of health and human services, or any successor agency, for studies of guaranteed annual income or other forms of income maintenance research projects; and for such purpose, the requirements of this title as to eligibility for medical assistance shall not apply for the term of and in accordance with the contract for such purpose.

(5) The state department is responsible for administering the delivery of medical assistance by county departments of social services or any other public or private entities participating in the delivery of medical assistance pursuant to this article and articles 5 and 6 of this title.

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 or someone acting on behalf of a recipient after the recipient or someone acting on behalf of the recipient files a complaint concerning services provided or not provided to the recipient:

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

(b) (I) An adverse action that negatively affects a recipient'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 income, resources, or health care needs that justifies the adverse action.

(II) No adverse action shall be taken against a recipient after a complaint has been filed until the recipient 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 not include instances where a recipient is not eligible for a service or program or where a provider documents a problem with a recipient and shares the documentation with the recipient or a third party prior to the recipient filing a complaint.

PART 2

ADMINISTRATION

25.5-4-201. Cash system of accounting - financial administration of medical

services premiums - medical programs administered by department of human services - federal contributions - rules. (1) The state department shall utilize the cash system of accounting, as enunciated by the governmental accounting standards board, regardless of the source of revenues involved, for all activities of the state department relating to the financial administration of any nonadministrative expenditure that qualifies for federal financial participation under Title XIX of the federal "Social Security Act", except for expenditures under the program for the medically indigent, article 3 of this title.

(1.5) (a) The state department shall utilize the cash system of accounting, as enunciated by the governmental accounting standards board, for the contributions required by 42 U.S.C. sec. 1396u-5 (c).

(b) The contributions required by 42 U.S.C. sec. 1396u-5 (c) shall be made in the manner required by the federal centers for medicare and medicaid services, or any successor agency. Nothing in this paragraph (b) shall require the state department to make the contribution before the contribution is due.

(2) The executive director shall promulgate rules to identify the programs utilizing the cash system of accounting.

25.5-4-202. Comprehensive plan for other services and benefits. In accordance with federal requirements pertaining to the development of a broad-based medical care program for low-income families, the state department shall prepare a comprehensive medical plan for consideration by the house and senate committees on health and human services, or any successor committees. The comprehensive plan shall include alternate means of expanding the medical care benefits and coverage provided in this article and articles 5 and 6 of this title. The comprehensive plan shall be reevaluated annually and shall be based upon a documented review of medical needs of low-income families in Colorado, a detailed analysis of priorities of service, coverage, and program costs, and an evaluation of progress. The medical advisory council appointed pursuant to this article shall assist the state department in the preparation of the comprehensive plan.

25.5-4-203. Advisory council established. There is hereby created a state medical assistance and services advisory council, referred to in this article as the "advisory council", consisting of sixteen members. Ex officio members of the advisory council shall be the executive directors of the state department and the department of health or their successors in function. The remaining members of the advisory council shall be appointed by the governor and shall be chosen by him to represent the various areas of medical services and the public. Specifically included shall be two members who are doctors of medicine licensed in this state, one doctor of osteopathy licensed in this

state, one dentist licensed in this state, one optometrist licensed in this state, one owner or operator of a licensed nursing facility in this state, one member who shall represent licensed hospitals in this state, one pharmacist licensed in this state, one professional nurse licensed in this state, one member who has provided home health care services for three years, and three members who are not directly associated with the areas of medical services to represent the public. The remaining member may represent any other area of medical services not specifically enumerated but shall not be limited thereto. Members shall serve at the pleasure of the governor and shall receive no compensation but shall be reimbursed 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.

25.5-4-204. Automated medical assistance administration. (1) The general assembly hereby finds and declares that the agency responsible for the administration of the state's medical assistance program would be more effective in its ability to streamline administrative functions of program administrators and providers under the program through the implementation of an automated system that will provide for the following:

- (a) Electronic claim submittals;
- (b) On-line eligibility determinations;
- (c) Electronic remittance statements;
- (d) Electronic fund transfers; and
- (e) Automation of other administrative functions associated with the medical assistance program.

(2) Therefore, the general assembly declares that it is appropriate to enact legislation, as set forth in subsection (3) of this section, that authorizes the state department to develop and implement an automated system for processing claims and payments under the medical assistance program, as well as for other administrative functions associated with the program.

(3) The executive director of the state department shall develop and implement an automated system through which medical assistance claims and payments and eligibility determinations or other related transactions may be processed. The system shall provide for the use of automated electronic technologies. The automated system may be implemented in phases if deemed necessary by the executive director. The automated system shall be implemented only after the executive director determines that:

- (a) Technology is available and proven to perform satisfactorily in a production environment;

- (b) Adequate financing is available to facilitate the implementation and maintenance of the system. Financing may include, but is not limited to, federal funds, appropriations from the general fund, provider transaction fees, or any other financing mechanisms which the state department may impose, and grants or contributions from

public or private entities.

- (c) The system has been successfully installed and fully tested; and
- (d) Adequate provider training has been provided for an orderly implementation.

25.5-4-205. Application - verification of eligibility - demonstration project - rules. (1) (a) Determination of eligibility for medical benefits shall be made by the county department in which the applicant resides, except as otherwise specified in this section. Local social security offices also determine eligibility for medicaid benefits at the same time they determine eligibility for supplemental security income. The state department may accept medical assistance applications and determine medical assistance eligibility and may designate the private service contractor that administers the children's basic health plan, Denver health and hospitals, a hospital that is designated as a regional pediatric trauma center, as defined in section 25-3.5-703 (4) (f), C.R.S., and other medical assistance sites determined necessary by the state department to accept medical assistance applications, to determine medical assistance eligibility, and to determine presumptive eligibility. When the state department determines that it is necessary to designate an additional medical assistance site, the state department shall notify the county in which the medical assistance site is located that an additional medical assistance site has been designated. Any person who is determined to be eligible pursuant to the requirements of this article and articles 5 and 6 of this title shall be eligible for benefits until such person is determined to be ineligible. Upon determination that any person is ineligible for medical benefits, the county department, the state department, or other entity designated by the state department shall notify the applicant in writing of its decision and the reason therefor. Separate determination of eligibility and formal application for benefits under this article and articles 5 and 6 of this title for persons eligible as provided in sections 25.5-5-101 and 25.5-5-201 shall be made in accordance with the rules of the state department.

(a.5) Repealed.

(a.7) As part of the medicaid eligibility modernization, the department is authorized to create a universal application for single point of entry for home- and community-based services waivers for children.

(b) The state department shall develop training safeguards to prevent actions taken by staff of medical assistance sites from affecting food and cash assistance eligibility.

(2) (a) Any married couple, at the beginning of a continuous period of institutionalization of one spouse, may request the county department to assess and document the total value of the resources of the couple, if the couple supplies to the county department the necessary information and documentation which is needed to make such an assessment.

(b) Any assessment prepared by the county department and provided to a couple

shall contain a procedure for appealing any determinations which have been made.

(c) If a request for assessment and documentation is not part of an application for medical assistance, the county department may establish a fee not exceeding the reasonable expenses of the county department of providing and documenting such assessment.

(3) (a) The state department shall promulgate rules to simplify the processing of applications in order that medical benefits are furnished to recipients as soon as possible, including rules that:

(I) Provide for initial processing of applications and determination of eligibility for medical assistance only at locations other than the county departments, at locations used for processing applications for the Colorado works program, or at the location used by the private service contractor that administers the children's basic health plan for determining eligibility of children for the plan; and

(II) May make provision for the payment of medical benefits for a period not to exceed three months prior to the date of application in cases where the applicant did not make application prior to his or her need for said medical benefits.

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

(A) To the extent authorized under federal law, require an applicant to state only the applicant's income and require the state department to verify the applicant's income through the most recently available records of the division of unemployment insurance in the department of labor and employment or through the income, eligibility, and verification system; except that the rules shall also allow an applicant to provide income information more recent than the records of the division of unemployment insurance or the income, eligibility, and verification system; and

(B) Require the state department at least annually to verify a recipient's income eligibility at reenrollment through the records of the division of unemployment insurance in the department of labor and employment or through the income, eligibility, and verification system and, if the recipient meets all eligibility requirements, permit the recipient to remain enrolled in the program. The rules shall also allow a recipient to supply income information more recent than the information supplied by the records of the division of unemployment insurance or the income, eligibility, and verification system.

(C) and (D) (Deleted by amendment, L. 2009, (SB 09-292), ch. 369, p. 1974, § 96, effective August 5, 2009.)

(I.5) (A) If the state department determines that a recipient was not eligible for medical benefits solely based upon the recipient's income after the recipient had been determined to be eligible based upon the records of the division of unemployment insurance or the income, eligibility, and verification system, the state department shall not pursue recovery from a county department for the cost of medical services provided to the recipient, and the county department is not responsible for any federal error rate sanctions

resulting from such determination.

(B) Notwithstanding any other provision in this paragraph (b), for applications that contain self-employment income, the state department shall not implement this paragraph (b) until it can verify self-employment income through the income, eligibility, and verification system or other verification as authorized by rules of the state department and federal law.

(II) Repealed.

(c) Adequate safeguards shall be established by the state department to ensure that only eligible persons receive benefits under this article and articles 5 and 6 of this title.

(d) (I) In addition, an applicant who is eighteen years of age or older shall be required to supply a form of personal photographic identification either by providing a valid Colorado driver's license or a valid identification card issued by the department of revenue pursuant to section 42-2-302, C.R.S. The state department may adopt rules that exempt applicants from the requirement of supplying a form of personal photographic identification if the requirement causes an unreasonable hardship or if the requirement is in conflict with federal law.

(II) The state department shall also adopt rules that allow for assistance to be provided on an emergency basis until the applicant is able to obtain or qualify for a driver's license or identification card; however, a county department or an entity designated by the state department pursuant to subsection (1) of this section is not required to recover emergency assistance from an applicant who fails, upon recertification, to meet the photographic identification requirement.

(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, or the parent or guardian of a recipient or enrollee 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 to apply for reenrollment either over the telephone or through the internet during a transition to a process that will serve recipients and enrollees statewide. The pilot program shall not serve as a replacement for a statewide process.

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

(C) Notwithstanding any other provision in this paragraph (e), the state department shall not implement or administer any portion of this paragraph (e) until spending authority has been received in the general appropriation act or any supplemental appropriation and shall only implement and administer this paragraph (e) to the extent of

such spending authority.

(III) The state department may solicit and accept gifts, grants, and donations from public or private sources for the development or implementation of reenrollment either over the telephone or through the internet process described in this paragraph (e); except that the state department may not accept a gift, grant, or donation that is subject to conditions that are inconsistent with this paragraph (e) or any other law. Any gifts, grants, or donations received by the state department shall be transmitted to the state treasurer, who shall credit the same to the department of health care policy and financing cash fund created pursuant to section 25.5-1-109.

(4) (a) By signing an application for medical assistance, a person assigns to the state department, by operation of law, all rights the applicant may have to medical support or payments for medical expenses from any other person on the applicant's own behalf or on behalf of any other member of the applicant's family for whom application is made. For purposes of this subsection (4), an assignment takes effect upon the determination that the applicant is eligible for medical assistance and up to three months prior to the date of application if the applicant meets the requirements of subsection (3) of this section and shall remain in effect so long as an individual is eligible for and receives medical assistance benefits. The application shall contain a statement explaining this assignment.

(b) An applicant for medical benefits upon initial application and each redetermination shall disclose any third party who may be responsible for the payment of medical expenses on behalf of the applicant or any other member of the applicant's family for whom application is made. As part of its medicaid eligibility modernization, the state department shall require the county department or other entity designated to accept applications for medical benefits to enter the third-party information into the automated system developed pursuant to section 25.5-4-204.

(5) (a) The state department shall not pursue recovery from a county for the cost of medical services provided to a person who has been incorrectly determined eligible for medical assistance by that county or any other entity.

(b) (Deleted by amendment, L. 2008, p. 2024, § 1, effective June 3, 2008.)

25.5-4-205.5. Confined persons - suspension of benefits. (1) For purposes of this section, unless the context otherwise requires, "confined person" means a person who is:

(a) An inmate confined to a correctional institution operated by or under contract with the department of corrections;

(b) Confined in a jail;

(c) Committed to a juvenile commitment facility;

(d) Committed to a department of human services facility pursuant to part 1 of article 8 of title 16, C.R.S.; or

(e) A patient placed in a department of human services facility pursuant to court order or certification.

(2) Notwithstanding any other provision of law, a person who, immediately prior to becoming a confined person, was a recipient of medical assistance pursuant to this article or article 5 or 6 of this title shall remain eligible for medical assistance while a confined person; except that no medical assistance shall be furnished pursuant to this article or article 5 or 6 of this title 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 corrections established pursuant to section 19-2-203, C.R.S., or the department of human services. Once a person is no longer a confined person, the person shall continue to be eligible for receipt of medical benefits pursuant to this article or article 5 or 6 of this title 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 shall not be included in any calculation of when the person must recertify his or her eligibility for medical assistance pursuant to this article or article 5 or 6 of this title.

25.5-4-206. Reimbursement to counties - costs of administration. The state department shall reimburse the county departments for costs of administration incurred by the counties under this article and articles 5 and 6 of this title in accordance with the provisions of section 26-1-122 (5), C.R.S.

25.5-4-207. Appeals. (1) (a) If an application for medical benefits is not acted upon by the county department within a reasonable time after filing of the same, or if an application is denied in whole or in part, or if medical benefits are suspended, terminated, or modified, the applicant or recipient, as the case may be, may appeal to the state department in the manner and form prescribed by the rules of the state department. 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 of medical assistance prior to appeal to the state department. Such 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 shall be consistent with rules promulgated by the state board pursuant to article 4 of title 24, C.R.S. The dispute resolution process shall include an opportunity for all clients to have a county conference, upon the client's request, and such requirement may be met through a telephonic conference upon the agreement of the client and the county department. The dispute resolution process need not 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 not resolved, the applicant or recipient may appeal to the state department in the manner and form prescribed by the rules of the state department. County notices to applicants or recipients shall inform them of the basis for the county's decision or action and shall inform them of their rights to a county conference under the dispute resolution process and of their rights to state level appeal and the process of making such appeal. The state board shall adopt rules setting forth what other issues, if any, may be appealed by an applicant or recipient to the state department. A hearing need not be granted when either state or federal law requires or results in a reduction or deletion of a medical benefit unless the applicant or recipient is arguing that his or her case does not fit within the parameters set forth by the change in the law. In notifying the applicant or recipient that an appeal is being denied because of a change in state or federal law, the state's notice shall inform the applicant or recipient that further appeal should be directed to the appropriate state or federal court.

(b) Upon receipt of an appeal, the state department shall give the appellant at least ten days' notice and an opportunity for a fair hearing in accordance with the rules of the state department. Any such fair hearing shall comply with section 24-4-105, C.R.S., and the state department's administrative law judge shall preside.

(c) The appellant shall have an opportunity to examine all applications and pertinent records concerning said appellant that constitute a basis for the denial, suspension, termination, or modification of medical benefits.

(2) All decisions of the state department shall be binding upon the county department involved and shall be complied with by such county department.

25.5-4-208. County duties - transitional medicaid. County departments shall assist families in completing the reporting requirements for transitional medicaid. This shall include informing 1931 medicaid recipients, as defined in section 25.5-4-103 (1), of the transitional medicaid eligibility requirements and the required reporting calendar.

25.5-4-209. Payments by third parties - copayments by recipients - review - appeal - children's waiting list reduction fund. (1) (a) Any recipient receiving benefits under this article or article 5 or 6 of this title 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 apply the supplemental income or insurance proceeds to the cost of the benefits rendered, and the rules may require reports from providers of other payments received by them from or on behalf of recipients.

(b) Subject to any limitations imposed by Title XIX, a recipient shall be required

to pay at the time of service a portion of the cost of any medical benefit rendered to the recipient or to the recipient's dependents pursuant to this article or article 5 or 6 of this title, as determined by rule of the state department.

(2) (a) Notwithstanding the provisions of section 26-1-114, C.R.S., the state department is authorized to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available, including the collection of sufficient information from individuals who are eligible for medical assistance to pursue claims against the third parties. The state department shall collect the information at the time of any determination or redetermination of eligibility for medical assistance. A knowing or willful failure of an individual to provide the information may result in the termination of the individual's eligibility for medical assistance.

(b) A third party, as a condition of doing business in the state, shall:

(I) (A) Provide on a monthly basis to the state department or its business associate eligibility records identifying all persons covered by the third party in a manner prescribed by rule to allow the state department or its business associate to perform an analysis and determine which persons are eligible for medical assistance;

(B) The eligibility record data elements provided by the third party shall be the minimum necessary to achieve a satisfactory data match. The third party shall provide, upon request of the state department or its business associate, additional data elements as needed to confirm eligibility matches as determined by the initial analysis, including, but not limited to, the name, address, and identifying number of the third party's plan.

(II) Accept the state's right of recovery and the assignment to the state of any right of an individual or other entity to payment from the third party for an item or service for which payment has been made under the medical assistance plan to the extent that such service is covered by the third party;

(III) Respond to any inquiry by the state regarding a claim for payment for any health care item or service that is submitted not later than three years after the date of the provision of the health care item or service; and

(IV) Agree not to deny a claim submitted by the state solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if:

(A) The claim is submitted by the state within the three-year period beginning on the date that the item or service is furnished; and

(B) Any action by the state to enforce its rights with respect to the claim is commenced within six years after the state's submission of the claim.

(c) The cost to a third party of providing data, including eligibility records, shall be borne by the state department.

(d) A third party that provides data required by the state department, whether confidential or not, shall not be held liable for the provision of such data to the state department or for any use made thereof.

(e) (I) The state department's business associate shall not use, transfer, extract, copy, revise, or store any data required to be provided to the state department and its business associate, including the eligibility records, social security numbers, coverage, nature of coverage, period provided, or any other data elements, for purposes other than:

(A) The identification of persons eligible to receive medical assistance, as defined by section 25.5-1-103 (5);

(B) Cost avoidance;

(C) The remuneration of the state department for services provided or paid for;

(D) Any record retention requirements;

(E) Audit requirements; and

(F) Purposes related to litigation and testimony.

(II) The state department's business associate shall destroy all data once the functions specified in subparagraph (I) of this paragraph (e) have been accomplished.

(f) (I) A Colorado resident shall have a private right of action against the state department's business associate if the business associate negligently uses the data specified in paragraph (e) of this subsection (2) for purposes other than those stated in paragraph (e) of this subsection (2). The right of action shall be enforceable in the courts of Colorado and limited to the actual damages incurred by the individual bringing the action.

(II) A third party may bring an action on behalf of a Colorado resident for injunctive relief against the state department's business associate to prevent the business associate from intentionally using the data for purposes other than those specified in paragraph (e) of this subsection (2).

(g) As used in this section:

(I) "Business associate" shall have the same meaning as provided in 45 CFR 160.103.

(II) "Third party" means a health insurer, self-insured plan, group health plan as defined in 29 U.S.C. sec. 1167 (1), service benefit plan, managed care organization, pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

(3) (a) The rights assigned by a recipient of medical assistance to the state department pursuant to section 25.5-4-205 (4) shall 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 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) 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.

(b) The state department shall enter into one or more agreements with an independent contractor to pursue recoveries from third parties pursuant to paragraph (a) of this subsection (3). Any such agreement shall provide that the independent contractor's only compensation shall be a prudent and reasonable percentage of the amount recovered on behalf of the state department as determined by the state department.

(c) (I) An independent contractor retained pursuant to paragraph (b) of this subsection (3) shall maintain a contemporaneous record of the hours of services provided and any costs incurred. When the matter is resolved, the independent contractor shall provide to the state department a statement of the hours of services provided, the amount of costs incurred, the total amount of the contingent fee, and the hourly rate for the services provided. The hourly rate for the services provided shall be determined by dividing the amount of the contingent fee, less the amount of costs incurred, by the number of hours of services provided by the independent contractor. The statement required by this subparagraph (I) shall be available for inspection and copying at reasonable times at the state department.

(II) Compliance with this paragraph (c) does not relieve a contracting attorney of any obligation or legal responsibility imposed by the Colorado rules of professional conduct or any provision of law.

(d) Nothing in this subsection (3) shall be construed to authorize 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.

(e) Repealed.

(4) With respect to programs administered by the state department, the state department shall access available data from the public assistance reporting information system for the purpose of identifying persons who are receiving certain public benefits from other states. The state department shall ensure that duplicate benefits are not being paid improperly to persons identified pursuant to the public assistance reporting information system.

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

(b) Notwithstanding any provision of paragraph (a) of this subsection (1) to the contrary, the state department, in purchasing health insurance for medical assistance

recipients 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 required of recipients for whom enrollment has been determined to be cost-effective as a condition of obtaining or retaining medical assistance. A parent shall be required to enroll a dependent child recipient, but medical assistance for such child shall not be 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 pursuant to subsection (1) of this section. Payment of said services shall be treated as payment for medical assistance. Coverage provided by the purchased health insurance plan shall be considered as third-party liability for the purposes of section 25.5-4-209.

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

25.5-4-211. Medicaid management information system - appropriation in annual general appropriation act - expenditure in next fiscal year. (1) Subject to the limitation in subsection (2) of this section, unexpended and unencumbered moneys from an appropriation in the annual general appropriation act to the state department for the medicaid management information system remain available for expenditure by the state department in the next fiscal year without further appropriation. This section applies to appropriations made by the general assembly for fiscal years beginning on and after July 1, 2013.

(2) On or before June 30, 2014, and on or before June 30 of each year thereafter, the state department shall notify the state controller of the amount of the appropriation from the annual general appropriation act for the medicaid management information system for the current fiscal year that the state department needs to remain available for expenditure in the next fiscal year. The state department may not expend more than the amount notified under the authority granted in this section.

(3) On or before January 2, 2015, and on or before January 2 of each year

thereafter, the state department shall report to the joint budget committee the amount of the appropriation from the prior fiscal year that remains available for the current fiscal year and the purpose for which the moneys are being used.

PART 3

RECOVERY

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

25.5-4-300.7. Prevention of coding errors - prepayment review of claims - report. (1) The state department shall implement and maintain a system for reducing medical services coding errors in medicaid claims submitted to the state department for reimbursement. The system shall include automatic, prepayment review of medicaid claims through the use of nationally recognized correct coding methods in the medicaid management information system, in accordance with 42 U.S.C. sec. 1396b (r) and regulations thereunder, as amended by Pub.L. 111-148, and any other subsequent acts of congress. The state department shall acquire and maintain any information technology necessary to implement the automated, prepayment review of medicaid claims.

(2) On or before January 31, 2011, and on or before January 31 each year thereafter, the state department shall submit to the joint budget committee of the general assembly and to the health and human services committees of the house of representatives and senate, or any successor committees, a report concerning the system implemented and maintained by the state department pursuant to subsection (1) of this section. The report shall include, at a minimum, the number and dollar value of medical services coding errors identified during the previous year through the use of the system.

25.5-4-301. Recoveries - overpayments - penalties - interest - adjustments - liens - review or audit procedures. (1) (a) (I) Except as provided in section 25.5-4-302 and subparagraph (III) of this paragraph (a), no recipient or estate of the recipient shall be 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, by this title, or by rules promulgated by the state board, which benefits are rendered to the recipient by a provider of medical services authorized to render such service in the state of Colorado,

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

(II) The provisions of subparagraph (I) of this paragraph (a) shall 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 shall be liable to a recipient or the estate of a recipient if the provider knowingly receives or seeks collection through a third party of an amount in violation of subparagraph (I) of this paragraph (a). The provider shall be liable for the amount unlawfully received, statutory interest on the amount received from the date of receipt until the date of repayment, plus a civil monetary penalty equal to one-half of the amount unlawfully received. When determining income or resources for purposes of determining eligibility or benefit amounts for any state-funded program under this title, the state department shall exclude from consideration any moneys received by a recipient pursuant to this subparagraph (II.5).

(B) In order to establish a claim for the penalty established by sub-subparagraph (A) of this subparagraph (II.5), a recipient or the estate of a recipient shall forward a notice of claim to the state department and to the provider. The executive director of the state department shall promulgate rules for an informal hearing process for determination of the issue that shall allow a provider an opportunity to be heard.

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

(III) (A) When a third party is primarily liable for the payment of the costs of a recipient's medical benefits, prior to receiving nonemergency medical care, the recipient 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 primary care physician. Any recipient 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, the items or services are nonreimbursable under this article and articles 5 and 6 of this title and the recipient is not liable to the provider.

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

(b) Recipient income applied pursuant to section 25.5-4-209 (1) shall not

disqualify any recipient, as defined in section 26-2-103 (8), C.R.S., from receiving benefits under this article, article 5 or 6 of this title, or public assistance under article 2 of title 26, C.R.S. If, at any time during the continuance of medical benefits, the recipient becomes possessed 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 notify the county department thereof, and the county department may, after investigation, either revoke such medical benefits or alter the amount thereof, as the circumstances may require.

(c) Any medical assistance paid to which a recipient was not lawfully entitled shall be recoverable from the recipient or the estate of the recipient 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 on account of medical assistance paid or to be paid on the recipient's behalf under this article or article 5 or 6 of this title, 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 be charged and paid to the county department on the amount of such medical assistance calculated at the legal rate and calculated from the date that payment for medical services rendered on behalf of the recipient is made to the date such amount is recovered.

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

(a) (I) If the state department makes a determination that such overpayment has been made as a result of the provider's false representation, the state department may collect the overpayment, plus a civil monetary penalty equal to one-half the amount of the overpayment, and interest on the sum of the two amounts accruing at the statutory rate from the date the overpayment is identified, by the means specified in this subsection (2). Such sum may be collected for up to the amount of time prescribed in section 13-80-103.5, C.R.S., after the overpayment is identified. Amounts remaining uncollected for more than the time period prescribed in section 13-80-103.5, C.R.S., after the last repayment was made may be considered uncollectible. For the purposes of this subparagraph (I), "false representation" means an inaccurate statement that is relevant to a claim for reimbursement and is made by a provider who has actual knowledge of the truth of false nature of the statement or by a provider acting in deliberate ignorance of or with reckless disregard for the truth of the statement. A provider acts with reckless disregard for truth if the provider fails to maintain records required by the department or if the provider fails to become familiar with rules, manuals, and bulletins issued by the department, board, or the department's fiscal agent.

(II) If the state department makes a determination that such overpayment has been

made for some other reason than a false representation by the provider specified in subparagraph (I) of this paragraph (a), 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 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) if it would be inequitable, uncollectible or administratively impracticable; except that no action shall be taken against a recipient 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. Amounts remaining uncollected for more than five years after the last repayment was made may be considered uncollectible.

(b) In order to collect the amounts specified in paragraph (a) of this subsection (2), the state department may withhold subsequent payments to which the provider is or becomes entitled and apply the amount withheld as an offset. The state board shall establish in rules the rate at which an overpayment may be offset, with provision for a reduction of such rate upon a good cause shown by the provider that the rate at which payment will be withheld will result in an undue hardship for the provider. In determining whether to grant a good cause reduction, the state department shall consider the impact of collecting the amount provided by state board rules on the quality of patient care and the financial viability of the provider. The state department may also take such other steps administratively as are available for the collection of the amounts specified in paragraph (a) of this subsection (2).

(c) If a provider defaults on repayment of the amounts specified in paragraph (a) of this subsection (2), the state department may bring a suit against the provider in the appropriate court. Court costs shall not be assessed against the state department but shall be assessed against the provider if the court finds in favor of the state department. Any costs collected by the state department shall be paid into the registry of the court. Once the amount has been reduced to judgment, the state department may proceed with all available postjudgment remedies.

(d) Notwithstanding the provisions of section 24-30-202.4, C.R.S., an amount specified in paragraph (a) of this subsection (2) that the state department has determined to be uncollectible may be referred to the controller for collection. Net proceeds of debts collected by the controller pursuant to this paragraph (d) shall be paid into the fund from which the overpayment was made.

(e) Any provider adversely affected by actions taken pursuant to this subsection (2), except when a suit is filed against the provider pursuant to paragraph (c) of this subsection (2), may appeal the determination of the state department pursuant to the provisions in section 24-4-105, C.R.S.

(f) If the state department, either directly or through a contracting agent,

undertakes a review or an audit of a provider to determine whether an overpayment has been made to that provider, the review or audit shall be subject to the procedures required in subsection (3) of this section.

(3) (a) A review or audit of a provider shall be subject to the following procedures:

(I) The reviewer or auditor shall conduct a review or audit in accordance with applicable state and federal law.

(II) The reviewer or auditor shall apply uniform standards and procedures to each class of providers subject to a review or an audit to determine an overpayment.

(III) The reviewer or auditor shall prepare findings for the entire period under review or audit, and a provider shall be subject to only one demand for repayment in connection with the review or audit.

(IV) The reviewer or auditor shall initiate each review or audit requiring an inspection of the provider's records by delivering to the provider not less than ten business days prior to the commencement of the audit a written request describing in detail such records and offering the provider the option of providing either a reproduction of such records or inspection by the reviewer or auditor at the provider's site. The request shall also clearly define milestone dates pertaining to records' requested due dates, permissible extensions of dates, the timelines for informal reconsideration, and deadlines for requesting a formal appeal. The records subject to the request shall be limited to records directly related to claims for reimbursement submitted by the provider. In the event such records are available from a county department of social services or another agency, subdivision, or contractor of the state, the reviewer or auditor shall request such records from such other agencies as may be appropriate prior to making a request to the provider. The reviewer or auditor shall conduct on-site inspections at reasonable times during regular business hours, and the reviewer or auditor shall make arrangements necessary for the reproduction of such records on site. If the provider chooses to provide a reproduction of the records requested by the reviewer or auditor instead of on-site inspection, the reviewer or auditor shall give the provider a reasonable period of time, that shall be not less than forty-five days, to provide such records taking into account the scope of the request, the time frame covered, and the reproduction arrangements available to the provider.

(IV.5) At the request of the provider, the reviewer or auditor shall conduct an in-person or telephonic interview with the provider prior to the preparation of a preliminary draft of the report of the reviewer or auditor at which the reviewer or auditor and the provider shall discuss:

(A) The findings of the reviewer or auditor;

(B) Any documentation useful for the provider to refute the findings of the reviewer or auditor; and

(C) The next steps in the review or audit process.

(V) A physician's record or other order for health care services, drugs, or medicinal supplies in a form transmitted electronically shall be sufficient to validate the provider's records regarding the ordering of the health care services, drugs, or medicinal supplies.

(VI) Whenever possible, the reviewer or auditor shall base a determination of an overpayment to a provider upon a review of actual records of the department, its agents, or the provider. In the event sufficient records are not available to the reviewer or auditor, an overpayment determination may be based upon a sampling of records so long as the sampling and any extrapolation therefrom is reasonably valid from a statistical standpoint and is in accordance with generally accepted auditing standards.

(VII) If a reviewer or auditor determines that there has been an overpayment to the provider, then, at the time demand for repayment is made, the state department shall offer the provider an informal reconsideration of the review or audit findings. The state department shall notify the provider in writing of the right to an informal reconsideration prior to implementing any recovery of an overpayment and give the provider an opportunity to request an informal reconsideration. In the event informal reconsideration is requested or a formal appeal is filed pursuant to subparagraph (VIII) of this paragraph (a), the state department shall not implement recovery of the overpayment until such informal reconsideration or formal appeal has been completed. Within forty-five days after the request for an informal reconsideration, the state department shall render a decision on the request and notify the provider of the decision. The notification shall include information concerning requesting a formal appeal, including informing the provider that the request must be filed within thirty days after the date of the state department's decision on the request for an informal reconsideration. If the state department is unable to render a decision on the request for informal reconsideration within forty-five days after the request, within forty-five days after the request, the state department shall notify the provider of its inability to complete the decision and shall include information concerning requesting a formal appeal, including informing the provider that the request must be filed within thirty days after the receipt of the notification that the state department is unable to render a decision. For purposes of this subparagraph (VII), an informal reconsideration shall be considered final thirty days after the earlier of the date on which the provider withdraws its request or the date on which the state department issues a written decision on the request.

(VIII) In accordance with paragraph (e) of subsection (2) of this section, any provider adversely affected by the actions of the state department or its contracting agent in connection with a review or an audit, including whether the state department or its contracting agent adhered to the provisions of this subsection (3) in making an overpayment determination, may appeal such actions pursuant to the provisions of section 24-4-105, C.R.S.

(a.5) Any additional review or audit procedures shall be adopted by rule of the

state board and shall be specifically referenced in any contract with a provider.

(b) The state department is authorized to engage the services of a qualified agent through a competitive contract issued pursuant to the state's procurement code for the purpose of conducting a review or audit of a provider to assist in determining whether there has been an overpayment to a provider and the amount of that overpayment. In addition to such terms and conditions as the state department may deem necessary, any contract shall be subject to the requirements for conducting a review or an audit in accordance with paragraph (a) of this subsection (3). The state department is further authorized to enter into a contract with a qualified agent for the purpose of conducting a review or an audit of a provider that provides that the compensation of the contracting agent shall be contingent and based upon a percentage of the amount of the recovery collected from the provider. A contract issued by the state department for the purpose of conducting a review or an audit of a provider to determine whether the provider has received an overpayment shall also be subject to the following conditions:

(I) The compensation paid to the contracting agent under a contingency-based contract shall not exceed eighteen percent of the amount finally collected from the provider overpayment, and the state department may establish a limit on the amount of annual compensation that may be paid to a contracting agent under a contingency-based contract and may further establish a limit on the amount that may be paid to a contracting agent under a contingency-based contract for recovery from any one provider.

(II) Reimbursement of the contracting agent's costs in performing the review or audit under a contingency-based contract shall be deemed included in the percentage compensation due the agent under the contract.

(III) No employee or agent of the contracting agent involved in the performance of a contingency-based contract shall be compensated by the contracting agent based upon the amount recovered under the contract.

(IV) The state department shall retain all authority for providing notice and otherwise making demand upon a provider for recovery of an overpayment, and the state department shall review and approve any written demand, request, or determination by the contracting agent regarding a review or an audit of a provider under this subsection (3).

(V) In any contingency-based contract authorized pursuant to this paragraph (b), the state of Colorado shall not be obligated to pay the contracting agent for amounts not actually collected from the provider.

(3.5) (a) Prior to the start of a contract to review or audit providers, the state department is encouraged to meet with organizations or associations of providers to educate providers on the review or audit process and the responsibilities of both the providers and the state department throughout the review or audit process. The state department is also encouraged to prepare an annual report on common findings following a contract to review or audit providers and distribute the report to organizations or

associations of providers. The annual report should include information to prevent similar findings in future reviews or audits and should direct providers to resource information.

(b) Repealed.

(4) If medical assistance is furnished to or on behalf of a recipient pursuant to the provisions of this article and articles 5 and 6 of this title for which a third party is liable, the state department has an enforceable right against such third party for the amount of such medical assistance, including the lien right specified in subsection (5) of this section. Whenever the recipient 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 and the recipient's attorney, if any. Any such agreement shall be filed with the court in which such an action is pending. The attorney named in such an agreement upon designation as a special assistant attorney general by the attorney general shall have the right to prove both the recipient'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 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 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 assignee, guardian, personal representative, estate, or survivors. When the state department intervenes in legal proceedings against the third party, it shall not be liable for any portion of the attorney fees or costs of the recipient.

(5) (a) When the state department has furnished medical assistance to or on behalf of a recipient pursuant to the provisions of this article, and articles 5 and 6 of this title, for which a third party is liable, the state department shall have an automatic statutory lien for all such medical assistance. The state department's lien shall be against any judgment, award, or settlement in a suit or claim against such third party and shall be in an amount that shall be 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 to recover damages for injuries, where the state department has a lien, shall be 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 each such party liable for the full amount of medical assistance furnished to or on behalf of the recipient for the injuries that are the subject of the judgment, award, or settlement.

(c) Except as otherwise provided in this article, the entire amount of any

judgment, award, or settlement of the recipient's action or claim, with or without suit, regardless of how characterized by the parties, shall be subject to the state department's lien.

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

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

(6) When the applicant or recipient, or his or her guardian, executor, administrator, or other appropriate representative, brings an action or asserts a claim against any third party, such 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 the recipient, legal guardian, executor, administrator, attorney, or other representative liable for the entire amount of medical assistance furnished to or on behalf of the recipient for the injuries that gave rise to the action or claim. The state department may, after thirty days' written notice to such person, enforce its 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 only if such person had knowledge that the recipient 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 agrees or is ordered to provide medical support or health insurance coverage for his or her dependents or other persons, and such dependents are applicants for, recipients of, or otherwise entitled to receive medical assistance pursuant to this article and articles 5 and 6 of this title, the state department shall be 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 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 and articles 5 and 6 of this title for whom the relative is legally responsible.

(8) All recipients of medical assistance under the medicaid program shall be deemed to have authorized their 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 the right of the state department to recover the medical assistance furnished to or on behalf of a recipient 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 any action upon the claim or cause of action of the applicant or recipient or his or her 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 the recovery for that portion of his or her medical costs or other damages not provided as medical assistance under this article or article 5 or 6 of this title.

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

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

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

(b) To enforce the right under this subsection (11), the county or state department may institute or intervene in legal proceedings against the trustee or person holding the power of attorney. Any amount of medical assistance recovered pursuant to this subsection (11) shall be distributed between the state and county in proportion to the amount of medical assistance paid by each respectively, if any.

(c) No action taken by the county or state department pursuant to this subsection (11) or any judgment rendered in such action or proceeding shall be a bar to any action upon the claim or cause of action of the recipient or his or her guardian, personal representative, estate, dependent, or survivors against the trustee or person holding the power of attorney.

(12) (a) An entity that provides managed care, as defined in section 25.5-5-403, that has entered into a risk contract with the state department shall have the same rights of the department set forth in this section except with respect to the rights described in subsections (5) and (6) of this section. In addition, the attorney general may not enforce the rights set forth in this subsection (12). Venue for an action brought by or on behalf of an entity pursuant to this subsection (12) shall be governed by the Colorado rules of civil procedure.

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

(c) In cases where the state department has recovery rights against a third party pursuant to subsections (4) and (5) of this section and an entity that provides managed

care has subrogation rights against the same party pursuant to paragraph (a) of this subsection (12), the recovery rights of the state department shall take precedence over the rights of the managed care plan.

(13) To the extent allowable under federal law, the state department shall recover from a legal immigrant's sponsor all medical assistance paid on behalf of a sponsored legal immigrant who is enrolled in the medical assistance program.

(14) Notwithstanding any provision of this section to the contrary:

(a) (I) The state department, or the state department's designated agent, shall conduct pre-enrollment and post-enrollment site visits of providers who are designated as moderate or high categorical risks to the medicaid program. The purpose of the site visit is to verify that the information submitted to the state department is accurate and to determine compliance with federal and state enrollment requirements.

(II) As established in rules promulgated by the state board, the state department may waive pre-enrollment and post-enrollment site visits of providers if the site visits are conducted by medicare or other federally designated entities.

(III) A provider is designated as a limited, moderate, or high categorical risk pursuant to the medicare program and federal regulations. If a provider is not designated in a risk category pursuant to the medicare program and federal regulations, the provider's risk category shall be established pursuant to rules promulgated by the state board.

(b) A provider enrolled in the medicaid program shall permit the centers for medicare and medicaid services or its agent or designated contractors and the state department or its agent to conduct unannounced, on-site inspections of any and all provider locations. Payment for any agent designated by the state department to perform on-site inspections shall not be based on any recoveries paid to the state department by a provider for violations discovered as a result of the on-site inspection.

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 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 would be a viable mechanism for such recipients 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.

(2) (a) Medical assistance paid on behalf of any individual who was fifty-five years of age or older when the individual received such assistance may be recovered by the state department from the estate of such individual in accordance with paragraph (c) of this subsection (2).

(b) Medical assistance paid on behalf of any individual who is institutionalized may be recovered by the state department from the estate of such individual in accordance with paragraph (c) of this subsection (2).

(c) The state department shall establish an estate recovery program only insofar as such program is in accordance with Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396p, as amended, and shall not take any action to recover medical assistance when the amount of assistance to be recovered is economically inappropriate in relation to expenses of recovery.

(3) The state department is authorized to file liens against any property of an individual who is institutionalized and from whom the state department may recover medical assistance pursuant to paragraph (b) of subsection (2) of this section.

(4) The state department may compromise, settle, or waive any recovery of medical assistance authorized pursuant to subsection (2) of this section upon good cause shown.

(5) Subject to any limitation concerning estate recovery in Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396p, as amended, the amount of any medical assistance paid pursuant to the provisions of this article and articles 5 and 6 of this title is a claim against the estate pursuant to the provisions of section 15-12-805 (1), C.R.S.

(6) The state board shall promulgate rules to implement the provisions of this section, including rules limiting the eligibility for medical assistance if the person made a voluntary assignment or transfer of property without fair and valuable consideration prior to applying for medical assistance. A contract for an exempt burial fund for an individual shall include a provision restricting the full amount to the cost of the burial and stating that any portion not expended for the burial costs shall be refunded to the state department by the mortuary as reimbursement for the cost of medical assistance provided to the individual. Said rules shall be in accordance with Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396p, as amended.

(7) Effective upon the implementation of a private-public partnership program for financing long-term care pursuant to section 25.5-6-110, this section shall apply to participants of such program only after excluding from the amount that may otherwise be recovered from such person's estate an amount allowed by rules adopted by the state board in accordance with section 25.5-6-110.

25.5-4-303. State income tax refund intercept - garnishment of earning - failure to provide medical support for child. (1) (a) At any time prescribed by the

department of revenue, but not less frequently than annually, the state department may certify to the department of revenue information regarding any person who:

(I) Is obligated to the state agency responsible for administering medical assistance in this state for medical support based on medical assistance provided to the obligor's dependent child; and

(II) Has received payment from a third party to cover the health care costs of the child but has neither applied such payment to cover the child's health care costs nor to reimburse the state department, the custodial parent of the child, or the provider of medical care.

(b) The information provided to the department of revenue shall include the name and the social security number of the person described in paragraph (a) of this subsection (1), the amount of medical assistance provided to the child during the period for which medical support was ordered but not provided as described in subparagraph (II) of paragraph (a) of this subsection (1), and any other identifying information required by the department of revenue.

(2) Prior to a final certification of the information described in subsection (1) of this section to the department of revenue, the state department shall notify the obligated person, in writing, that the state intends to refer the person's name to the department of revenue in an attempt to offset the person's medical support obligation against the person's state income tax refund. Such notification shall include information on the parent's right to object to the offset.

(3) Upon notification by the department of revenue of amounts deposited with the state treasurer pursuant to section 39-21-108 (3), C.R.S., the state department may recover the amount of the medical assistance described in paragraph (b) of subsection (1) of this section.

(4) The state department may garnish the wages and other earnings of a person described in paragraph (a) of subsection (1) of this section. The garnishment of wages and earnings shall be in accordance with articles 54 and 54.5 of title 13, C.R.S.

(5) The state board shall adopt rules as are necessary for the implementation of this section.

25.5-4-303.3. Provider fraud - attorney general report. (1) On or before January 15, 2013, and on or before January 15 each year thereafter, the attorney general shall submit a written report to the judiciary committee and the health and environment committee of the house of representatives, or their successor committees, and to the judiciary committee and the health and human services committee of the senate, or their successor committees, relating to medicaid provider fraud including, at a minimum:

(a) Investigations of provider fraud during the year;

(b) Criminal complaints requested, cases dismissed, cases acquitted, convictions,

and confessions of judgment;

(c) Recoveries, including fines and penalties, restitution ordered, and restitution collected;

(d) Civil claims; and

(e) Trends in methods used to commit provider fraud, excluding law enforcement-sensitive information.

25.5-4-303.5. Short title. This section and sections 25.5-4-304 to 25.5-4-310 shall be known and may be cited as the "Colorado Medicaid False Claims Act".

25.5-4-304. Definitions. As used in sections 25.5-4-303.5 to 25.5-4-309, unless the context otherwise requires:

(1) (a) "Claim" means a request or demand for money or property, whether under a contract or otherwise, and regardless of whether the state has title to the money or property, under the "Colorado Medical Assistance Act" that is:

(I) Presented to an officer, employee, or agent of the state; or

(II) Made to a contractor, grantee, or other recipient if the money or property is to be spent or used on the state's behalf or to advance a program or interest of the state and if the state:

(A) Provides or has provided any portion of the money or property requested or demanded; or

(B) Will reimburse the contractor, grantee, or other recipient for any portion of the money or property that is requested or demanded.

(b) "Claim" does not include a request or demand for money or property that the state has paid to an individual as compensation for employment by the state or as an income subsidy with no restriction on that individual's use of the money or property.

(2) "Colorado Medical Assistance Act" means this article and articles 5 and 6 of this title.

(3) (a) "Knowing" or "knowingly" means that a person, with respect to information:

(I) Has actual knowledge of the information;

(II) Acts in deliberate ignorance of the truth or falsity of the information; or

(III) Acts in reckless disregard of the truth or falsity of the information.

(b) "Knowing" or "knowingly" does not require proof of specific intent to defraud.

(4) "Material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

(5) "Obligation" means a fixed or contingent duty arising from an express or implied contractual, quasi-contractual, grantor-grantee, licensor-licensee, statutory, fee-

based, or similar relationship, or the retention of overpayment.

25.5-4-305. False medicaid claims - liability for certain acts. (1) Except as otherwise provided in subsection (2) of this section, a person is liable to the state for a civil penalty of not less than five thousand five hundred dollars and not more than eleven thousand dollars; except that these upper and lower limits on liability shall automatically increase to equal the civil penalty allowed under the federal "False Claims Act", 31 U.S.C. sec. 3729, et seq., if and as the penalties in such federal act may be adjusted for inflation as described in said act in accordance with the federal "Civil Penalties Inflation Adjustment Act of 1990", Pub. L. No. 101-410, plus three times the amount of damages that the state sustains because of the act of that person, if the person:

(a) Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(b) Knowingly makes, uses, or causes to be made or used a false record or statement material to a false or fraudulent claim;

(c) Has possession, custody, or control of property or money used, or to be used, by the state in connection with the "Colorado Medical Assistance Act" and knowingly delivers, or causes to be delivered, less than all of the money or property;

(d) Authorizes the making or delivery of a document certifying receipt of property used, or to be used, by the state in connection with the "Colorado Medical Assistance Act" and, intending to defraud the state, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(e) Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the state in connection with the "Colorado Medical Assistance Act" who lawfully may not sell or pledge the property;

(f) Knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state in connection with the "Colorado Medical Assistance Act", or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the state in connection with the "Colorado Medical Assistance Act";

(g) Conspires to commit a violation of paragraphs (a) to (f) of this subsection (1).

(2) Notwithstanding the amount of damages authorized in subsection (1) of this section, for a person who violates subsection (1) of this section, the court may assess not less than twice the amount of damages that the state sustains because of the act of the person if the court finds that:

(a) The person who committed the violation of subsection (1) of this section furnished to the officials of the state responsible for investigating false claims violations all information about the violation known to the person and furnished said information within thirty days after the date on which the person first obtained the information;

(b) At the time the person furnished the information about the violation to the state, a criminal prosecution, civil action, or administrative action had not commenced with respect to the violation and the person did not have actual knowledge of the existence of an investigation into the violation; and

(c) The person fully cooperated with any investigation of the violation by the state.

(3) A person violating this section shall also be liable to the state for the costs of a civil action brought to recover any penalty or damages.

(4) Any information furnished pursuant to subsection (2) of this section shall be exempt from disclosure under part 2 of article 72 of this title.

25.5-4-306. Civil actions for false medicaid claims. (1) Responsibility of attorney general. The attorney general shall diligently investigate a violation under section 25.5-4-305. If the attorney general finds that a person has violated or is violating section 25.5-4-305, the attorney general may bring a civil action under this section against the person.

(2) **Actions by private persons.** (a) A relator may bring a civil action for a violation of section 25.5-4-305 on behalf of the relator and the state. The action shall be brought in the name of the state. The action may be dismissed only if the court and the attorney general give written consent to the dismissal and their reasons for consenting.

(b) A copy of the complaint and written disclosure of substantially all material evidence and information the relator possesses shall be served on the state pursuant to rule 4 of the Colorado rules of civil procedure. The complaint shall be filed in camera, shall remain under seal for at least sixty days, and shall not be served on the defendant until the court so orders. The state may elect to intervene and proceed with the action within sixty days after it receives both the complaint and the material evidence and information.

(c) The state may, for good cause shown, move the court for extensions of the time during which the complaint remains under seal under paragraph (b) of this subsection (2). Any such motion may be supported by affidavits or other submissions in camera. The defendant shall not be required to respond to a complaint filed under this section until twenty days after the complaint is unsealed and served upon the defendant pursuant to rule 4 of the Colorado rules of civil procedure.

(d) Before the expiration of the sixty-day period pursuant to paragraph (b) of this subsection (2) or any extensions obtained under paragraph (c) of this subsection (2), the state shall:

(I) Proceed with the action, in which case the state shall conduct the action; or

(II) Notify the court that it declines to take over the action, in which case the relator shall have the right to conduct the action.

(e) When a relator brings an action under this subsection (2), no person other than the state may intervene or bring a related action based on the facts underlying the pending action.

(3) **Rights of parties to private actions.** (a) If the state proceeds with an action brought under subsection (2) of this section, it shall have the primary responsibility for prosecuting the action and shall not be bound by an act of the relator. The relator shall have the right to continue as a party to the action, subject to the limitations set forth in paragraph (b) of this subsection (3).

(b) (I) The state may dismiss the action notwithstanding the objections of the relator if the relator has been notified by the state of the filing of the motion and the court has provided the relator with an opportunity for a hearing on the motion.

(II) The state may settle the action with the defendant notwithstanding the objections of the relator if the court determines, after a hearing, that the proposed settlement is fair, adequate, and reasonable under all the circumstances. Upon a showing of good cause, the hearing may be held in camera.

(III) Upon a showing by the state that unrestricted participation during the course of the litigation by the relator would interfere with or unduly delay the state's prosecution of the case, or would be repetitious, irrelevant, or for purposes of harassment, the court may, in its discretion, impose limitations on the relator's participation, including but not limited to:

- (A) Limiting the number of witnesses the relator may call;
- (B) Limiting the length of the testimony of the witnesses;
- (C) Limiting the relator's cross-examination of witnesses; or
- (D) Otherwise limiting the participation by the relator in the litigation.

(IV) Upon a showing by the defendant that unrestricted participation during the course of the litigation by the relator would be for purposes of harassment or would cause the defendant undue burden or unnecessary expense, the court may limit the participation by the relator in the litigation.

(c) If the state elects not to proceed with the action, the relator who initiated the action shall have the right to conduct the action. If the state so requests, it shall be served with copies of all pleadings filed in the action and, at the state's expense, shall be supplied with copies of all deposition transcripts. When a relator proceeds with the action, the court, without limiting the status and rights of the relator, may nevertheless permit the state to intervene at a later date upon a showing of good cause.

(d) Regardless of whether the state proceeds with the action, upon a showing by the state that certain actions of discovery by the relator would interfere with the state's investigation or prosecution of a criminal or civil matter arising out of the same facts, the court may stay the discovery for a period of not more than sixty days. The showing shall be conducted in camera. The court may extend the sixty-day period upon a further showing in camera that the state has pursued the criminal or civil investigation or

proceedings with reasonable diligence and that any proposed discovery in the civil action will interfere with the ongoing criminal or civil investigation or proceedings.

(e) Notwithstanding the provisions of subsection (2) of this section, the state may elect to pursue its claim through any alternate remedy available to the state, including any administrative proceeding to determine a civil money penalty. If an alternate remedy is pursued in another proceeding, the relator shall have the same rights in the proceeding as the relator would have had if the action had continued under this section. Any finding of fact or conclusion of law made in another proceeding that has become final shall be conclusive on all parties to an action under this section. For purposes of this paragraph (e), a finding or conclusion is final if it has been finally determined on appeal to the appropriate court of the state, if all time for filing such an appeal with respect to the finding or conclusion has expired, or if the finding or conclusion is not subject to judicial review.

(4) **Award to private persons.** (a) (I) If the state proceeds with an action brought by a relator under subsection (2) of this section, the relator shall, subject to subparagraph (II) of this paragraph (a), receive at least fifteen percent but not more than twenty-five percent of the proceeds of the action or settlement of the claim, depending upon the extent to which the relator substantially contributed to the prosecution of the action.

(II) If the court finds the action to be based primarily on disclosures of specific information, other than information provided by the relator, relating to allegations or transactions in a criminal, civil, or administrative hearing, in a legislative, administrative, or state auditor's report, hearing, audit, or investigation, or from the news media, the court may award to the relator such sums as it considers appropriate, but in no case more than ten percent of the proceeds, taking into account the significance of the information and the role of the relator in advancing the case to litigation.

(III) Any payment to a relator under subparagraph (I) or (II) of this paragraph (a) shall be made from the proceeds. The relator shall also receive an amount for reasonable expenses that the court finds to have been necessarily incurred plus reasonable attorney fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.

(b) If the state does not proceed with an action brought under subsection (2) of this section, the relator bringing the action or settling the claim shall receive an amount that the court decides is reasonable for collecting the civil penalty and damages. The amount shall be not less than twenty-five percent and not more than thirty percent of the proceeds of the action or settlement and shall be paid out of the proceeds. The relator shall also receive an amount for reasonable expenses that the court finds to have been necessarily incurred, plus reasonable attorney fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.

(c) Regardless of whether the state proceeds with an action brought under subsection (2) of this section, if the court finds that the action was brought by a relator who planned and initiated the violation of section 25.5-4-305 upon which the action was

brought, then the court may, to the extent the court considers appropriate, reduce the share of the proceeds of the action that the relator would otherwise receive under paragraph (a) or (b) of this subsection (4), taking into account the role of the relator in advancing the case to litigation and any relevant circumstances pertaining to the violation. If the relator is convicted of criminal conduct arising from his or her role in the violation of section 25.5-4-305, the relator shall be dismissed from the civil action and shall not receive any share of the proceeds of the action. Such dismissal shall not prejudice the right of the state to continue the action.

(d) If the state does not proceed with an action brought under subsection (2) of this section and the relator bringing the action conducts the action, the court may award to the defendant its reasonable attorney fees and expenses if the defendant prevails in the action and the court finds that the claim of the relator was clearly frivolous, clearly vexatious, or brought primarily for purposes of harassment.

(5) **Certain actions barred.** (a) A court shall not have jurisdiction over an action brought under this section against a member of the general assembly, a member of the state judiciary, or an elected official in the executive branch of the state of Colorado if the action is based on evidence or information known to the state when the action was brought.

(b) A relator shall not bring an action under subsection (2) of this section that is based upon allegations or transactions that are the subject of a civil suit or an administrative civil money penalty proceeding in which the state is already a party.

(c) (I) A court shall dismiss an action or claim brought under subsection (2) of this section unless opposed by the state, if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed in a state criminal, civil, or administrative hearing in which the state or its agent is a party, in a legislative, administrative, or state auditor's report, hearing, audit, or investigation, or by the news media, unless the action is brought by the state or the relator is an original source of the information.

(II) For purposes of this paragraph (c), "original source" means an individual who, prior to a public disclosure under subparagraph (I) of this paragraph (c), has voluntarily disclosed to the state the information on which the allegations or transactions in a claim are based, or who has knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and has voluntarily provided the information to the state before filing an action under subsection (2) of this section.

(6) **State not liable for certain expenses.** The state is not liable for expenses that a relator incurs in bringing an action under this section.

(7) **Private action for retaliation.** (a) An employee, contractor, or agent shall be entitled to all relief necessary to make the employee, contractor, or agent whole, if the employee, contractor, or agent is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment

by the defendant or by any other person because of lawful acts done by the employee, contractor, or agent, or associated others in furtherance of an action under this section or in furtherance of an effort to stop any violations of section 25.5-4-305.

(b) (I) An employee, contractor, or agent who seeks relief pursuant to this subsection (7) shall be entitled to all relief necessary to make the employee, contractor, or agent whole. Such relief shall include:

(A) Reinstatement with the same seniority status the employee, contractor, or agent would have had but for the discrimination, twice the amount of back pay, and interest on the back pay; and

(B) Compensation for any special damages sustained as a result of the discrimination or retaliation, including litigation costs and reasonable attorney fees.

(II) An employee, contractor, or agent may bring an action in the appropriate court of the state for the relief provided in this subsection (7).

25.5-4-307. False medicaid claims procedures - statute of limitations. (1) A civil action under section 25.5-4-306 (1) or (2) may not be brought after the later of:

(a) More than six years after the date on which the violation of section 25.5-4-305 is committed; or

(b) More than three years after the date when facts material to the right of action are known or reasonably should have been known by the official of the state charged with responsibility to act in the circumstances, but in no event more than ten years after the date on which the violation of section 25.5-4-305 is committed.

(2) If the state elects to intervene and proceed with an action brought under section 25.5-4-306, the state may file its own complaint or amend the relator's complaint to clarify or add detail to the claims in which the state is intervening and to add any additional claims with respect to which the state contends it is entitled to relief. For statute of limitations purposes, any such pleadings by the state shall relate back to the filing date of the relator's complaint, to the extent that the state's claim arises out of the conduct, transactions, or occurrences set forth, or attempted to be set forth, in the prior complaint of the relator.

(3) In an action brought under section 25.5-4-306, the state or relator must prove all essential elements of the cause of action, including damages, by a preponderance of the evidence.

(4) Notwithstanding any other provision of law, the Colorado rules of criminal procedure, or the Colorado rules of evidence, a final judgment rendered in favor of the state in a criminal proceeding charging fraud or false statements, whether upon a verdict after trial or upon a plea of guilty or nolo contendere, shall estop the defendant from denying the essential elements of the offense in any action that involves the same transaction as in the criminal proceeding and that is brought under section 25.5-4-306.

(5) A private action for retaliation under section 25.5-4-306 (7) may not be brought more than three years after the date when the retaliation occurred.

25.5-4-308. False medicaid claims jurisdiction. An action under section 25.5-4-306 may be brought in any judicial district in which the defendant or, in the case of multiple defendants, any one defendant can be found, resides, or transacts business or in which an act proscribed by section 25.5-4-305 occurred. A summons as required by the Colorado rules of civil procedure shall be issued by the appropriate district court and served at any place.

25.5-4-309. False medicaid claims civil investigation demands. (1) General.
(a) (I) Whenever the attorney general has reason to believe that a person may be in possession, custody, or control of documentary material or information relevant to a false medicaid claims law investigation, the attorney general may, before commencing a civil proceeding under section 25.5-4-306 or other false medicaid claims law or making an election under section 25.5-4-306 (2) (d), issue in writing and cause to be served upon the person a civil investigative demand requiring the person to:

(A) Produce the documentary material for inspection and copying;
(B) Answer in writing written interrogatories with respect to the documentary material or information;

(C) Give oral testimony concerning the documentary material or information; or

(D) Furnish any combination of such material, answers, or testimony.

(II) The attorney general may not delegate the authority to issue civil investigative demands under this subsection (1). Whenever a civil investigative demand is an express demand for any product of discovery, the attorney general, the deputy attorney general, or an assistant attorney general shall cause to be served, in any manner authorized by this section, a copy of the demand upon the person from whom the discovery was obtained and shall notify the person to whom the demand is issued of the date on which the copy was served.

(b) (I) Each civil investigative demand issued under this subsection (1) shall state the nature of the conduct constituting the alleged violation of a false medicaid claims law that is under investigation and the applicable provision of law alleged to be violated.

(II) If the demand is for the production of documentary material, the demand shall:

(A) Describe each class of documentary material to be produced with such definiteness and certainty as to permit the material to be fairly identified;

(B) Prescribe a return date for each such class that will provide a reasonable period of time within which the material so demanded may be assembled and made

available for inspection and copying; and

(C) Identify the false medicaid claims law investigator to whom the material shall be made available.

(III) If the demand is for answers to written interrogatories, the demand shall:

(A) Specify the written interrogatories to be answered;

(B) Prescribe dates on which answers to written interrogatories shall be submitted;

and

(C) Identify the false medicaid claims law investigator to whom the answers shall be submitted.

(IV) If the demand is for the giving of oral testimony, the demand shall:

(A) Prescribe a date, time, and place at which oral testimony shall be commenced and notify the deponent if the oral testimony is to be video or audio recorded;

(B) Identify a false medicaid claims law investigator who shall conduct the examination and the custodian to whom the transcript of the examination shall be submitted;

(C) Specify that such attendance and testimony are necessary to the conduct of the investigation;

(D) Notify the person receiving the demand of the right to be accompanied by an attorney and any other representative; and

(E) Describe the general purpose for which the demand is being issued and the general nature of the testimony, including the primary areas of inquiry, that will be taken pursuant to the demand.

(V) A civil investigative demand issued under this section that is an express demand for any product of discovery shall not be returned or returnable until twenty days after a copy of the demand has been served upon the person from whom the discovery was obtained.

(VI) The date prescribed for the commencement of oral testimony pursuant to a civil investigative demand issued under this section shall be a date that is not less than seven days after the date on which the demand is received, unless the attorney general or an assistant attorney general designated by the attorney general determines that exceptional circumstances are present that warrant the commencement of the testimony within a lesser period of time.

(VII) The attorney general shall not authorize the issuance under this section of more than one civil investigative demand for oral testimony by the same person unless the person requests otherwise or unless the attorney general, after investigation, notifies that person in writing that an additional demand for oral testimony is necessary. Notwithstanding section 24-31-103, C.R.S., the attorney general shall not authorize the performance, by any other officer, employee, or agency, of any function vested in the attorney general under this subparagraph (VII).

(2) **Protected material or information.** (a) A civil investigative demand issued

under subsection (1) of this section shall not require the production of documentary material, the submission of answers to written interrogatories, or the giving of oral testimony if the material, answers, or testimony would be protected from disclosure under:

(I) The standards applicable to subpoenas or subpoenas duces tecum issued by a court of this state to aid in a grand jury investigation; or

(II) The standards applicable to discovery requests under the Colorado rules of civil procedure, to the extent that the application of the standards to any such demand is appropriate and consistent with the provisions and purposes of this section.

(b) A demand that is an express demand for a product of discovery supersedes any inconsistent order, rule, or provision of law, other than this section, preventing or restraining disclosure of the product of discovery to a person. Disclosure of a product of discovery pursuant to an express demand does not constitute a waiver of any right or privilege that the person making the disclosure may be entitled to invoke to resist discovery of trial preparation materials.

(3) Service and jurisdiction. (a) A civil investigative demand issued under subsection (1) of this section or a petition brought pursuant to subsection (10) of this section may be served by a false medicaid claims law investigator, a sheriff, or a deputy sheriff at any place within the state.

(b) A civil investigative demand issued under subsection (1) of this section or a petition filed under subsection (10) of this section may be served upon a person who is not found within the state in the manner prescribed by the Colorado rules of civil procedure for service in another state or a foreign country. To the extent that the courts of this state can assert jurisdiction over any such person consistent with due process, the district court for the city and county of Denver shall have the same jurisdiction to take an action respecting compliance with this section by any such person that the court would have if the person were personally within the jurisdiction of the court.

(4) Service on legal entities and natural persons. (a) Service of a civil investigative demand issued under subsection (1) of this section or of a petition filed under subsection (10) of this section may be made upon a partnership, corporation, association, or other legal entity by:

(I) Delivering an executed copy of the demand or petition to a partner, executive officer, managing agent, or general agent of the partnership, corporation, association, or entity, or to an agent authorized by appointment or by law to receive service of process on behalf of the partnership, corporation, association, or entity;

(II) Delivering an executed copy of the demand or petition to the principal office or place of business of the partnership, corporation, association, or entity; or

(III) Depositing an executed copy of the demand or petition in the United States mail by registered or certified mail, with a return receipt requested, addressed to the partnership, corporation, association, or entity at its principal office or place of business.

(b) Service of a civil investigative demand issued under subsection (1) of this section or of a petition filed under subsection (10) of this section may be made upon a natural person by:

(I) Delivering an executed copy of the demand or petition to the person; or

(II) Depositing an executed copy of the demand or petition in the United States mail by registered or certified mail, with a return receipt requested, addressed to the person at the person's residence, principal office, or place of business.

(5) **Proof of service.** A verified return by the individual serving a civil investigative demand issued under subsection (1) of this section or a petition filed under subsection (10) of this section setting forth the manner of the service shall be proof of the service. In the case of service by registered or certified mail, the return shall be accompanied by the return post office receipt of delivery of the demand.

(6) **Documentary material.** (a) (I) The production of documentary material in response to a civil investigative demand issued under subsection (1) of this section shall be made under a sworn certificate, in the form as the demand designates, by:

(A) In the case of a natural person, the person to whom the demand is directed; or

(B) In the case of a person other than a natural person, a person having knowledge of the facts and circumstances relating to the production and authorized to act on behalf of the person.

(II) The certificate shall state that all of the documentary material required by the demand and in the possession, custody, or control of the person to whom the demand is directed has been produced and made available to the false medicaid claims law investigator identified in the demand.

(b) A person upon whom a civil investigative demand for the production of documentary material has been served under this section shall make the material available for inspection and copying to the false medicaid claims law investigator identified in the demand at the principal place of business of the person, or at such other place as the false medicaid claims law investigator and the person thereafter may agree and prescribe in writing, or as the court may direct under subsection (10) of this section. The material shall be made so available on the return date specified in the demand, or on such later date as the false medicaid claims law investigator may prescribe in writing. The person may, upon written agreement between the person and the false medicaid claims law investigator, substitute copies for originals of all or any part of the material.

(7) **Interrogatories.** (a) Each interrogatory in a civil investigative demand issued under subsection (1) of this section shall be answered separately and fully in writing under oath and shall be submitted under a sworn certificate, in the form the demand designates, by:

(I) In the case of a natural person, the person to whom the demand is directed; or

(II) In the case of a person other than a natural person, the person or persons responsible for answering each interrogatory.

(b) If an interrogatory is objected to, the reasons for the objection shall be stated in the certificate instead of an answer. The certificate shall state that all information required by the demand and in the possession, custody, control, or knowledge of the person to whom the demand is directed has been submitted. To the extent that any information is not furnished, the information shall be identified and reasons set forth with particularity regarding the reasons why the information was not furnished.

(8) **Oral examinations.** (a) The examination of a person pursuant to a civil investigative demand for oral testimony issued under subsection (1) of this section shall be taken before an officer authorized to administer oaths and affirmations by the laws of the United States, the state of Colorado, or the place where the examination is held. The officer before whom the testimony is to be taken shall put the witness on oath or affirmation and shall, personally or with the assistance of someone acting under the direction of the officer and in the officer's presence, record the testimony of the witness. The testimony shall be taken stenographically and shall be transcribed. When the testimony is fully transcribed, the officer before whom the testimony is taken shall promptly transmit a copy of the transcript of the testimony to the custodian. This subsection (8) shall not preclude the taking of testimony by any means authorized by, and in a manner consistent with, the Colorado rules of civil procedure.

(b) The false medicaid claims law investigator conducting the examination shall exclude from the place where the examination is held all persons except the person giving the testimony, the attorney for and any other representative of the person giving the testimony, the attorney for the state, any person who may be agreed upon by the attorney for the state and the person giving the testimony, the officer before whom the testimony is to be taken, and the stenographer who is recording the testimony.

(c) The oral testimony of a person taken pursuant to a civil investigative demand served under this section shall be taken in the judicial district of the state within which the person resides, is found, or transacts business, or in another place as may be agreed upon by the false medicaid claims law investigator conducting the examination and the person.

(d) When the testimony is fully transcribed, the false medicaid claims law investigator or the officer before whom the testimony is taken shall afford the witness, who may be accompanied by counsel, a reasonable opportunity to examine and read the transcript, unless the witness waives the examination and reading. Any changes in form or substance that the witness desires to make shall be entered and identified upon the transcript by the officer or the false medicaid claims law investigator, with a statement of the reasons given by the witness for making the changes. The transcript shall then be signed by the witness, unless the witness in writing waives the signing, is ill, cannot be found, or refuses to sign. If the witness does not sign the transcript within thirty days after being afforded a reasonable opportunity to examine it, the officer or the false medicaid claims law investigator shall sign it and state on the record the fact of the waiver, illness, absence of the witness, or refusal to sign, together with the reasons, if any, given therefor.

(e) The officer before whom the testimony is taken shall certify on the transcript that the witness was sworn by the officer and that the transcript is a true record of the testimony given by the witness, and the officer or false medicaid claims law investigator shall promptly deliver the transcript, or send the transcript by registered or certified mail, to the custodian.

(f) Upon payment of reasonable charges therefor, the false medicaid claims law investigator shall furnish a copy of the transcript to the witness only; except that the attorney general, the deputy attorney general, or an assistant attorney general may, for good cause, limit the witness to inspection of the official transcript of the testimony of the witness.

(g) (I) A person compelled to appear for oral testimony under a civil investigative demand issued under subsection (1) of this section may be accompanied, represented, and advised by counsel. Counsel may advise the person, in confidence, with respect to any question asked of the person. The person or counsel may object on the record to any question, in whole or in part, and shall briefly state for the record the reason for the objection. An objection may be made, received, and entered upon the record when it is claimed that the person is entitled to refuse to answer the question on the grounds of any constitutional or other legal right or privilege, including the privilege against self-incrimination. The person may not otherwise object to or refuse to answer any question and may not directly or through counsel otherwise interrupt the oral examination. If the person refuses to answer a question, the false medicaid claims law investigator may file a petition in a district court under paragraph (a) of subsection (10) of this section for an order compelling the person to answer the question.

(II) If the person refuses to answer a question on the grounds of the privilege against self-incrimination, the false medicaid claims law investigator may compel the testimony of the person in accordance with the provisions of section 13-90-118, C.R.S.

(III) A person appearing for oral testimony under a civil investigative demand issued under subsection (1) of this section shall be entitled to the same fees and allowances that are paid to witnesses in the district courts of this state.

(9) **Custodian of documents, answers, and transcripts.** (a) The attorney general shall designate a false medicaid claims law investigator to serve as custodian of documentary material, answers to interrogatories, and transcripts of oral testimony received under this section and shall designate such additional false medicaid claims law investigators as the attorney general determines from time to time to be necessary to serve as deputies to the custodian.

(b) (I) A false medicaid claims law investigator who receives any documentary material, answers to interrogatories, or transcripts of oral testimony under this section shall transmit them to the custodian. The custodian shall take physical possession of the material, answers, or transcripts and shall be responsible for the use made of them and for the return of documentary material under paragraph (d) of this subsection (9).

(II) The custodian may cause the preparation of copies of the documentary material, answers to interrogatories, or transcripts of oral testimony as may be required for official use by a false medicaid claims law investigator or other officer or employee of the department of law who is authorized for such use under regulations that the attorney general shall issue. The material, answers, and transcripts may be used by any such authorized false medicaid claims law investigator or other officer or employee in connection with the taking of oral testimony under this section.

(III) (A) Except as otherwise provided in this subsection (9), documentary material, answers to interrogatories, or transcripts of oral testimony, or copies thereof, while in the possession of the custodian, shall not be available for examination by an individual other than a false medicaid claims law investigator or other officer or employee of the department of law authorized under subparagraph (II) of this paragraph (b).

(B) Sub-subparagraph (A) of this subparagraph (III) shall not apply if consent is given by the person who produced the material, answers, or transcripts or, in the case of any product of discovery produced pursuant to an express demand for the material, if consent is given by the person from whom the discovery was obtained.

(C) Nothing in this subparagraph (III) is intended to prevent disclosure to the general assembly, including any committee of the general assembly, or to any other agency of the state for use by the agency in furtherance of its statutory responsibilities. Disclosure of information to any such other agency shall be allowed only upon application, made by the attorney general to a district court, showing substantial need for the use of the information by the agency in furtherance of its statutory responsibilities.

(IV) While in the possession of the custodian and under such reasonable terms and conditions as the attorney general shall prescribe:

(A) Documentary material and answers to interrogatories shall be available for examination by the person who produced the material or answers, or by a representative of that person authorized by that person to examine the material and answers; and

(B) Transcripts of oral testimony shall be available for examination by the person who produced the testimony or by a representative of that person authorized by that person to examine the transcripts.

(c) Whenever an attorney of the department of law has been designated to appear before a court, grand jury, or state agency in a case or proceeding, the custodian of any documentary material, answers to interrogatories, or transcripts of oral testimony received under this section may deliver to the attorney such material, answers, or transcripts for official use in connection with the case or proceeding as the attorney determines to be required. Upon the completion of the case or proceeding, the attorney shall return to the custodian the material, answers, or transcripts so delivered that are not in the control of the court, grand jury, or agency through introduction into the record of the case or proceeding.

(d) The custodian shall, upon written request of a person who produced any

documentary material in the course of any false medicaid claims law investigation pursuant to a civil investigative demand under this section, return to the person any such material, other than copies furnished to the false medicaid claims law investigator under paragraph (b) of subsection (6) of this section or made for the department of law under subparagraph (II) of paragraph (b) of this subsection (9), that is not in the control of a court, grand jury, or agency through introduction into the record of the case or proceeding, if:

(I) A case or proceeding before a court or grand jury arising out of the investigation or any proceeding before a state agency involving the material has been completed; or

(II) A case or proceeding in which the material may be used has not been commenced within a reasonable time after completion of the examination and analysis of all documentary material and other information assembled in the course of the investigation.

(e) (I) In the event of the death, disability, or separation from service in the department of law of the custodian of any documentary material, answers to interrogatories, or transcripts of oral testimony produced pursuant to a civil investigative demand under this section, or in the event of the official relief of the custodian from responsibility for the custody and control of the material, answers, or transcripts, the attorney general shall promptly:

(A) Designate another false medicaid claims law investigator to serve as custodian of the material, answers, or transcripts; and

(B) Transmit in writing to the person who produced the material, answers, or testimony notice of the identity and address of the successor so designated.

(II) A person who is designated to be a successor under this paragraph (e) shall have, with regard to the material, answers, or transcripts, the same duties and responsibilities as were imposed by this section upon that person's predecessor in office; except that the successor shall not be held responsible for any default or dereliction that occurred before that designation.

(10) **Judicial proceedings.** (a) Whenever a person fails to comply with a civil investigative demand issued under subsection (1) of this section, or whenever satisfactory copying or reproduction of the material requested in a demand cannot be done and the person refuses to surrender the material, the attorney general may file, in a district court for the judicial district in which the person resides, is found, or transacts business, and serve upon the person a petition for an order of the court for the enforcement of the civil investigative demand.

(b) (I) A person who has received a civil investigative demand issued under subsection (1) of this section may file a petition for an order of the court to modify or set aside the demand. The person shall file the petition in a district court for the judicial district within which the person resides, is found, or transacts business and shall serve a

copy of the petition upon the false medicaid claims law investigator identified in the demand. In the case of a petition addressed to an express demand for a product of discovery, the person may file a petition to modify or set aside the demand only in the district court for the judicial district in which the proceeding in which the discovery was obtained is or was last pending. The person shall file a petition under this subparagraph (I):

(A) Within twenty days after the date of service of the civil investigative demand or at any time before the return date specified in the demand, whichever date is earlier; or

(B) Within such longer period as may be prescribed in writing by a false medicaid claims law investigator identified in the demand.

(II) The petition shall specify each ground upon which the petitioner relies in seeking relief under subparagraph (I) of this paragraph (b) and may be based upon any failure of the demand to comply with the provisions of this section or upon any constitutional or other legal right or privilege of the person. During the pendency of the petition in the court, the court may stay, as it deems proper, the running of the time allowed for compliance with the demand, in whole or in part; except that the person filing the petition shall comply with any portions of the demand not sought to be modified or set aside.

(c) (I) In the case of a civil investigative demand issued under subsection (1) of this section that is an express demand for a product of discovery, the person from whom the discovery was obtained may file a petition for an order of the court to modify or set aside those portions of the demand requiring production of any product of discovery. The person shall file the petition in the district court for the judicial district in which the proceeding in which the discovery was obtained is or was last pending and shall serve a copy of the petition upon the false medicaid claims law investigator identified in the demand and upon the recipient of the demand. The person shall file a petition under this subparagraph (I):

(A) Within twenty days after the date of service of the civil investigative demand or at any time before the return date specified in the demand, whichever date is earlier; or

(B) Within such longer period as may be prescribed in writing by the false medicaid claims law investigator identified in the demand.

(II) The petition shall specify each ground upon which the petitioner relies in seeking relief under subparagraph (I) of this paragraph (c), and may be based upon any failure of the portions of the demand from which relief is sought to comply with the provisions of this section or upon any constitutional or other legal right or privilege of the petitioner. During the pendency of the petition, the court may stay, as it deems proper, compliance with the demand and the running of the time allowed for compliance with the demand.

(d) At any time during which a custodian is in custody or control of any documentary material or answers to interrogatories produced, or transcripts of oral

testimony given, by a person in compliance with a civil investigative demand issued under subsection (1) of this section, the person, and in the case of an express demand for any product of discovery, the person from whom the discovery was obtained, may file a petition for an order of the court to require the performance by the custodian of any duty imposed upon the custodian by this section. The person shall file the petition in the district court for the judicial district within which the office of the custodian is situated and shall serve a copy of the petition upon the custodian.

(e) Whenever a petition is filed in a district court under this subsection (10), the court shall have jurisdiction to hear and determine the matter so presented and to enter such order or orders as may be required to carry out the provisions of this section. A final order so entered shall be subject to appeal under section 13-4-102, C.R.S. Any disobedience of a final order entered by a court under this section shall be punished as a contempt of the court.

(f) The Colorado rules of civil procedure shall apply to a petition under this subsection (10) to the extent that the rules are consistent with the provisions of this section.

(11) **Disclosure exemption.** Any documentary material, answers to written interrogatories, or oral testimony provided under a civil investigative demand issued under subsection (1) of this section shall be exempt from disclosure under section 24-72-203, C.R.S.

(12) **Definitions.** As used in this section, unless the context otherwise requires:

(a) "Custodian" means the custodian, or any deputy custodian, designated by the attorney general under paragraph (a) of subsection (9) of this section.

(b) "Documentary material" means the original or a copy of a book, record, report, memorandum, paper, communication, tabulation, chart, or other document, or data compilations stored in or accessible through computer or other information retrieval systems, together with instructions and all other materials necessary to use or interpret the data compilations, and any product of discovery.

(c) "False medicaid claims law" means:

(I) This section and sections 25.5-4-303.5 to 25.5-4-308; and

(II) Any law enacted before, on, or after May 26, 2010, that prohibits or makes available to the state in a court of the state a civil remedy with respect to a false medicaid claim against, bribery of, or corruption of an officer or employee of the state.

(d) "False medicaid claims law investigation" means an inquiry conducted by a false medicaid claims law investigator for the purpose of ascertaining whether a person is or has been engaged in a violation of a false medicaid claims law.

(e) "False medicaid claims law investigator" means an attorney or investigator employed by the department of law who is charged with the duty of enforcing or carrying into effect a false medicaid claims law or an officer or employee of the state acting under the direction and supervision of the attorney or investigator in connection with a false

medicaid claims law investigation.

(f) "Person" means a natural person, partnership, corporation, association, or other legal entity.

(g) "Product of discovery" means:

(I) The original or duplicate of a deposition, interrogatory, document, thing, result of the inspection of land or other property, examination, or admission, any one of which is obtained by a method of discovery in a judicial or administrative proceeding of an adversarial nature;

(II) A digest, analysis, selection, compilation, or derivation of an item listed in subparagraph (I) of this paragraph (g); and

(III) An index or other manner of access to an item listed in subparagraph (I) of this paragraph (g).

25.5-4-310. Medicaid false claims report. (1) On or before January 15, 2012, and on or before each January 15 thereafter, the attorney general shall submit a written report to the health and human services committees of the senate and the house of representatives, or any successor committees, and to the joint budget committee of the general assembly concerning claims brought under the "Colorado Medicaid False Claims Act" during the previous fiscal year. The report shall include, but not be limited to:

(a) The number of actions filed by the attorney general;

(b) The number of actions filed by the attorney general that were completed;

(c) The amount that was recovered in actions filed by the attorney general through settlement or through a judgment and, if known, the amount recovered for damages, penalties, and litigation costs;

(d) The number of actions filed by a person other than the attorney general;

(e) The number of actions filed by a person other than the attorney general that were completed;

(f) The amount that was recovered in actions filed by a person other than the attorney general through settlement or through a judgment and, if known, the amount recovered for damages, penalties, and litigation costs, and the amount recovered by the state and the person; and

(g) The amount expended by the state for investigation, litigation, and all other costs for claims related to the "Colorado Medicaid False Claims Act".

PART 4

PROVIDERS - REIMBURSEMENT

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

(b) (I) On and after July 1, 1992, the state department rules established for the payment of providers under this article and articles 5 and 6 of this title shall provide that services that are compensable under both Title XIX and Title XVIII of the social security act shall be paid at either the rate established under Title XIX or the rate established under Title XVIII, whichever is lower.

(II) If any provision of this paragraph (b) is found to be in conflict with any federal law or regulation, such conflicting portion of this paragraph (b) is declared to be inoperative to the extent of the conflict.

(c) The state department shall exercise its overexpenditure authority under section 24-75-109, C.R.S., and shall not intentionally interrupt the normal provider payment schedule unless notified jointly by the director of the office of state planning and budgeting and the state controller that there is the possibility that adequate cash will not be available to make payments to providers and for other state expenses. If it is determined that adequate cash is not available and the state department does interrupt the normal payment cycle, the state department shall notify the joint budget committee of the general assembly and any affected providers in writing of its decision to interrupt the normal payment schedule. Nothing in this paragraph (c) shall be interpreted to establish a right for any provider to be paid during any specific billing cycle.

(d) Repealed.

(2) As to all payments made pursuant to this article and articles 5 and 6 of this title, the state department rules for the payment of providers may include provisions that encourage the highest quality of medical benefits and the provision thereof at the least expense possible.

(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.

(b) (I) In order to provide medical benefits under this article and articles 5 and 6 of this title on a capitated basis and subject to the condition imposed in subparagraph (II) of this paragraph (b), the state department is authorized to solicit negotiated contracts with providers based upon the requirements of this subsection (3). The state department may contract with one or more providers concerning the same medical services in a single

geographic area.

(II) The state department may award a contract to one or more providers pursuant to subparagraph (I) of this paragraph (b) when the executive director determines that such contract will reduce the costs of providing medical benefits under this article and articles 5 and 6 of this title.

(III) The state department may define groups of recipients 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 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), the executive director of the state department has the authority to require a recipient of the medicaid program to select a managed care provider and to assign a recipient to a managed care provider if the recipient has failed to make a selection within a reasonable time. To the extent possible, this requirement shall 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 procedures and instructions for disenrollment and shall have adequate staff to explain issues concerning service delivery and disenrollment procedures to recipients, including staff to address the communications needs and requirements of recipients with disabilities.

(II) All recipients shall be adequately informed about service delivery options available to them consistent with the provisions of this subparagraph (II). If a recipient does not respond to a state department request for selection of a delivery option within forty-five calendar days, the state department shall send a second notification to the recipient. If the recipient does not respond within twenty days of the date of the second notification, the state department shall ensure that the recipient remains with the recipient's primary care physician, regardless of whether said primary care physician is enrolled in a health maintenance organization.

(5) The state board may promulgate rules to provide for the implementation and administration of subsections (3) and (4) of this section.

(6) The state department shall make good faith efforts to obtain a waiver or waivers from any requirements of Title XIX of the social security act which would prohibit the implementation of subsections (3) and (4) of this section. Such waiver or waivers shall be obtained from the federal department of health and human services, or

any successor agency. If such waivers are not granted, the state department shall not act to implement or administer subsections (3) and (4) of this section to the extent that Title XIX prohibits it.

25.5-4-402. Providers - hospital reimbursement - rules. (1) For all licensed or certified hospitals contracting for services under this article and articles 5 and 6 of this title, except those hospitals operated by the department of human services or those hospitals deemed exempt by the state board, the state department shall pay for inpatient hospital services pursuant to a system of prospective payment, generally based on the elements of a diagnosis-related group system. The state department shall develop and administer a system for ensuring appropriate utilization and quality of care provided by those providers who are reimbursed under this section. Subject to available appropriations, the state department may also make supplemental medicaid payments to certain hospitals. The state board shall promulgate rules to provide for the implementation of this section.

(2) (a) A hospital that receives payment under this article and articles 5 and 6 of this title for telemedicine services shall employ its existing quality-of-care protocols and patient confidentiality guidelines to ensure that such services meet the requirements of this article and articles 5 and 6 of this title.

(b) The executive director of the state department shall adopt rules in furtherance of this subsection (2), including, without limitation, rules to:

- (I) Ensure the provision of appropriate care to patients;
- (II) Prevent fraud and abuse; and
- (III) Establish methods and procedures to avoid overuse of telemedicine services.

(3) (a) In addition to the reimbursement rate process described in subsection (1) of this section and subject to adequate funding made available pursuant to section 25.5-4-402.3, the state department shall pay an additional amount based upon performance to those hospitals that provide services that improve health care outcomes for their patients. This amount shall be determined by the state department based upon nationally recognized performance measures established in rules adopted by the state board. The state quality standards shall be consistent with federal quality standards published by an organization with expertise in health care quality, including but not limited to, the centers for medicare and medicaid services, the agency for healthcare research and quality, or the national quality forum.

(b) The amount of the payments made pursuant to this subsection (3) shall be computed annually. For the first two fiscal years that payments are made pursuant to this subsection (3), the total amount of the payments shall be up to five percent of the total reimbursements made to hospitals in the previous year. For each fiscal year after the first two fiscal years, the total amount of the payments shall be up to seven percent of the total

reimbursements made to hospitals in the previous year.

25.5-4-402.3. Providers - hospital - provider fees - legislative declaration - federal waiver - fund created - rules - advisory board - repeal. (1) **Short title.** This section shall be known and may be cited as the "Health Care Affordability Act of 2009".

(2) **Legislative declaration.** The general assembly hereby finds and declares that:

(a) The state and the providers of publicly funded medical services, and hospital providers in particular, share a common commitment to comprehensive health care reform;

(b) Hospital providers within the state incur significant costs by providing uncompensated emergency department care and other uncompensated medical services to low-income and uninsured populations; and

(c) This section is enacted as part of a comprehensive health care reform and is intended to provide the following state services and benefits:

(I) Providing a payer source for some low-income and uninsured populations who may otherwise be cared for in emergency departments and other settings in which uncompensated care is provided;

(II) Reducing the underpayment to Colorado hospitals participating in publicly funded health insurance programs;

(III) Reducing the number of persons in Colorado who are without health care benefits;

(IV) Reducing the need of health care providers to shift the cost of providing uncompensated care to other payers; and

(V) Expanding access to high-quality, affordable health care for low-income and uninsured populations.

(3) **Hospital provider fee.** (a) Beginning with the fiscal year commencing July 1, 2009, and each fiscal year thereafter, the state department is authorized to charge and collect hospital provider fees, as described in 42 CFR 433.68 (b), on outpatient and inpatient services provided by all licensed or certified hospitals, referred to in this section as "hospitals", for the purpose of obtaining federal financial participation under the state medical assistance program as described in this article and articles 5 and 6 of this title, referred to in this section as the "state medical assistance program", and the Colorado indigent care program described in part 1 of article 3 of this title, referred to in this section as the "Colorado indigent care program". The hospital provider fees shall be used to:

(I) Increase reimbursement to hospitals for providing medical care under:

(A) The state medical assistance program; and

(B) The Colorado indigent care program;

(II) Increase the number of persons covered by public medical assistance;

(III) Pay the administrative costs to the state department in implementing and administering this section; and

(IV) Offset general fund expenditures for the state medicaid program for state fiscal years 2011-12 and 2012-13 only.

(b) The provider fees shall be assessed pursuant to rules adopted by the state board, pursuant to section 24-4-103, C.R.S. The amount of the fee shall be established by rule of the state board but shall not exceed the federal limit for such fees. In establishing the amount of the fee and in promulgating the rules governing the fee, the state board shall:

(I) Consider recommendations of the hospital provider fee oversight and advisory board established pursuant to subsection (6) of this section;

(II) Establish the amount of the provider fee so that the amount collected from the fee and federal matching funds associated with the fee are sufficient to pay for the items described in paragraph (a) of this subsection (3), but nothing in this subparagraph (II) shall require the state board to increase the provider fee above the amount recommended by the advisory board; and

(III) Establish the amount of the provider fee so that the amount collected from the fee is approximately equal to or less than the amount of the appropriation specified for the fee in the general appropriation act or any supplemental appropriation act.

(c) (I) In accordance with the redistributive method set forth in 42 CFR 433.68 (e) (1) and (e) (2), the state department may seek a waiver from the broad-based provider fees requirement or the uniform provider fees requirement, or both. Subject to federal approval and to minimize the financial impact on certain hospitals, the state department, in consultation with the advisory board, may exempt from payment of the provider fee certain types of hospitals, including but not limited to:

(A) Psychiatric hospitals, as licensed by the department of public health and environment;

(B) Hospitals that are licensed as general hospitals and certified as long-term care hospitals by the department of public health and environment;

(C) Critical access hospitals that are licensed as general hospitals and are certified by the department of public health and environment under 42 CFR part 485, subpart F;

(D) Inpatient rehabilitation facilities; or

(E) Hospitals specified for exemption under 42 CFR 433.68 (e).

(II) In determining whether a hospital may be excluded, the state department shall use one or more of the following criteria:

(A) A hospital that is located in a rural area;

(B) A hospital with which the state department does not contract to provide services under the state medical assistance program;

(C) A hospital whose inclusion or exclusion would not significantly affect the net benefit to hospitals paying the provider fee; or

(D) A hospital that must be included to receive federal approval.

(III) The state department may reduce the amount of the provider fee for certain hospitals to obtain federal approval and to minimize the financial impact on certain hospitals. In determining for which hospitals the state department may reduce the amount of the provider fee, the state department shall use one or more of the following criteria:

(A) The hospital is a type of hospital described in subparagraph (I) of this paragraph (c);

(B) The hospital is located in a rural area;

(C) The hospital serves a higher percentage than the average hospital of persons covered by the state medical assistance program, medicare, or commercial insurance or persons enrolled in a managed care organization;

(D) The hospital does not contract with the state department to provide services under the state medical assistance program;

(E) If the hospital paid a reduced provider fee, the reduced provider fee would not significantly affect the net benefit to hospitals paying the provider fee; or

(F) The hospital is required not to pay a reduced provider fee as a condition of federal approval.

(d) The state department may, with the approval of the advisory board, alter the process prescribed in this subsection (3) to the extent necessary to meet the federal requirements and to obtain federal approval.

(e) (I) The state board, in consultation with the advisory board, shall promulgate rules on the calculation, assessment, and timing of the provider fee. The state department shall assess the provider fee on a schedule to be set by the state board through rule. The state board rules shall require that the periodic provider fee payments from a hospital and the state department's reimbursement to the hospital under subparagraphs (I) and (II) of paragraph (b) of subsection (4) of this section are due as nearly simultaneously as feasible; except that the state department's reimbursement to the hospital shall be due no more than two days after the periodic provider fee payment is received from the hospital. The provider fee shall be imposed on each hospital even if more than one hospital is owned by the same entity. The fee shall be prorated and adjusted for the expected volume of service for any year in which a hospital opens or closes.

(II) The state department is authorized to refund any unused portion of the provider fee. For any portion of the provider fee that has been collected by the state department but for which the state department has not received federal matching funds, the state department shall refund back to the hospital that paid the fee the amount of such portion of the fee within five business days after the fee is collected.

(III) The state board, in consultation with the advisory board, shall promulgate rules on the reports that hospitals shall be required to submit for the state department to calculate the amount of the provider fee. Notwithstanding the provisions of part 2 of article 72 of title 24, C.R.S., information provided to the state department pursuant to this

section shall be considered confidential and shall not be deemed a public record. Nonetheless, the state department, in consultation with the advisory board, may prepare and release summaries of the reports to the public.

(f) A hospital shall not include any amount of the provider fee as a separate line item in its billing statements.

(g) The state board shall promulgate any rules pursuant to the "State Administrative Procedure Act", article 4 of title 24, C.R.S., necessary for the administration and implementation of this section. Prior to submitting any proposed rules concerning the administration or implementation of the provider fee to the state board, the state department shall consult with the advisory board on the proposed rules as specified in paragraph (e) of subsection (6) of this section.

(4) **Hospital provider fee cash fund.** (a) All provider fees collected pursuant to this section by the state department shall be transmitted to the state treasurer, who shall credit the same to the hospital provider fee cash fund, which fund is hereby created and referred to in this section as the "fund".

(b) All moneys in the fund shall be subject to federal matching as authorized under federal law and subject to annual appropriation by the general assembly for the following purposes:

(I) To maximize the inpatient and outpatient hospital reimbursements to up to the upper payment limits as defined in 42 CFR 447.272 and 42 CFR 447.321;

(II) To increase hospital reimbursements under the Colorado indigent care program to up to one hundred percent of the hospital's costs of providing medical care under the program;

(III) To pay the quality incentive payments provided in section 25.5-4-402 (3);

(IV) Subject to available revenue from the provider fee and federal matching funds, to expand eligibility for public medical assistance by:

(A) Increasing the eligibility level for parents and caretaker relatives of children who are eligible for medical assistance, pursuant to section 25.5-5-201 (1) (m), from sixty-one percent to one hundred thirty-three percent of the federal poverty line;

(B) Increasing the eligibility level for children and pregnant women under the children's basic health plan to up to two hundred fifty percent of the federal poverty line;

(C) Providing eligibility under the state medical assistance program for a childless adult or an adult without a dependent child in the home, pursuant to section 25.5-5-201 (1) (p), who earns up to one hundred thirty-three percent of the federal poverty line;

(D) Providing a buy-in program in the state medical assistance program for disabled adults and children whose families have income of up to four hundred fifty percent of the federal poverty line;

(V) To provide continuous eligibility for twelve months for children enrolled in the state medical assistance program;

(VI) To pay the state department's actual administrative costs of implementing and

administering this section, including but not limited to the following costs:

(A) Expenses of the advisory board, including but not limited to the state department's personal services and operating costs related to the administration of the advisory board;

(B) The state department's actual costs related to implementing and maintaining the provider fee, including personal services, operating, and consulting expenses;

(C) The state department's actual costs for the changes and updates to the medicaid management information system for the implementation of subparagraphs (I) to (III) of this paragraph (b);

(D) The state department's personal services and operating costs related to personnel, consulting services, and for review of hospital costs necessary to implement and administer the increases in inpatient and outpatient hospital payments made pursuant to subparagraph (I) of this paragraph (b), increases in the Colorado indigent care program payments made pursuant to subparagraph (II) of this paragraph (b), and quality incentive payments made pursuant to subparagraph (III) of this paragraph (b);

(E) The state department's actual costs for the changes and updates to the Colorado benefits management system and medicaid management information system to implement and maintain the expanded eligibility provided for in subparagraphs (IV) and (V) of this paragraph (b);

(F) The state department's personal services and operating costs related to personnel necessary to implement and administer the expanded eligibility for public medical assistance provided for in subparagraphs (IV) and (V) of this paragraph (b), including but not limited to administrative costs associated with the determination of eligibility for public medical assistance by county departments;

(G) The state department's personal services, operating, and systems costs related to expanding the opportunity for individuals to apply for public medical assistance directly at hospitals or through another entity outside the county departments, in connection with section 25.5-4-205, that would increase access to public medical assistance and reduce the number of uninsured served by hospitals; and

(VII) To offset the loss of any federal matching funds due to a decrease in the certification of the public expenditure process for outpatient hospital services for medical services premiums that were in effect as of July 1, 2008.

(VIII) Repealed.

(IX) (A) For state medicaid expenditures for state fiscal year 2011-12 only, fifty million dollars shall be appropriated to offset general fund expenditures.

(B) For state medicaid expenditures for state fiscal year 2012-13 only, twenty-five million dollars shall be appropriated to offset general fund expenditures.

(C) This subparagraph (IX) is repealed, effective December 31, 2013.

(c) Any moneys in the fund not expended for the purposes described in paragraph (b) of this subsection (4) may be invested by the state treasurer as provided by law. All

interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund. Any unexpended and unencumbered moneys remaining in the fund at the end of any fiscal year shall remain in the fund and shall not be credited or transferred to the general fund or any other fund but shall be appropriated by the general assembly for the purposes described in paragraph (b) of this subsection (4) in future fiscal years.

(5) **Appropriations.** (a) (I) The provider fee is to supplement, not supplant, general fund appropriations to support hospital reimbursements as of July 1, 2009. General fund appropriations for hospital reimbursements shall be maintained at the level of appropriations in the medical services premium line item made for the fiscal year commencing July 1, 2008; except that general fund appropriations for hospital reimbursements may be reduced if an index of appropriations to other providers shows that general fund appropriations are reduced for other providers. If the index shows that general fund appropriations are reduced for other providers, the general fund appropriations for hospital reimbursements shall not be reduced by a greater percentage than the reductions of appropriations for the other providers as shown by the index.

(II) If general fund appropriations for hospital reimbursements are reduced below the level of appropriations in the medical services premium line item made for the fiscal year commencing July 1, 2008, the general fund appropriations will be increased back to the level of appropriations in the medical services premium line item made for the fiscal year commencing July 1, 2008, at the same percentage as the appropriations for other providers as shown by the index. The general assembly is not obligated to increase the general fund appropriations back to the level of appropriations in the medical services premium line item in a single fiscal year and such increases may occur over nonconsecutive fiscal years.

(III) For purposes of this paragraph (a), the "index of appropriations to other providers" or "index" shall mean the average percent change in reimbursement rates through appropriations or legislation enacted by the general assembly to home health providers, physician services, and outpatient pharmacies, excluding dispensing fees. The state board, after consultation with the advisory board, is authorized to clarify this definition as necessary by rule.

(b) If the revenue from the provider fee is insufficient to fully fund all of the purposes described in paragraph (b) of subsection (4) of this section:

(I) The general assembly is not obligated to appropriate general fund revenues to fund such purposes;

(II) The hospital provider reimbursement and quality incentive payment increases described in subparagraphs (I) to (III) of paragraph (b) of subsection (4) of this section and the costs described in subparagraphs (VI) and (VII) of paragraph (b) of subsection (4) of this section shall be fully funded using revenue from the provider fee and federal matching funds before any eligibility expansion is funded; and

(III) (A) If the state board promulgates rules that expand eligibility for medical assistance to be paid for pursuant to subparagraph (IV) of paragraph (b) of subsection (4) of this section, and the state department thereafter notifies the advisory board that the revenue available from the provider fee and the federal matching funds will not be sufficient to pay for all or part of the expanded eligibility, the advisory board shall recommend to the state board reductions in medical benefits or eligibility so that the revenue will be sufficient to pay for all of the reduced benefits or eligibility. After receiving the recommendations of the advisory board, the state board shall adopt rules providing for reduced benefits or reduced eligibility for which the revenue shall be sufficient and shall forward any adopted rules to the joint budget committee. Notwithstanding the provisions of section 24-4-103 (8) and (12), C.R.S., following the adoption of rules pursuant to this sub-subparagraph (A), the state board shall not submit the rules to the attorney general and shall not file the rules with the secretary of state until the joint budget committee approves the rules pursuant to sub-subparagraph (B) of this subparagraph (III).

(B) The joint budget committee shall promptly consider any rules adopted by the state board pursuant to sub-subparagraph (A) of this subparagraph (III). The joint budget committee shall promptly notify the state department, the state board, and the advisory board of any action on such rules. If the joint budget committee does not approve the rules, the joint budget committee shall recommend a reduction in benefits or eligibility so that the revenue from the provider fee and the matching federal funds will be sufficient to pay for the reduced benefits or eligibility. After approving the rules pursuant to this sub-subparagraph (B), the joint budget committee shall request that the committee on legal services, created pursuant to section 2-3-501, C.R.S., extend the rules as provided for in section 24-4-103 (8), C.R.S., unless the committee on legal services finds after review that the rules do not conform with section 24-4-103 (8) (a), C.R.S.

(C) After the state board has received notification of the approval of rules adopted pursuant to sub-subparagraph (A) of this subparagraph (III), the state board shall submit the rules to the attorney general pursuant to section 24-4-103 (8) (b), C.R.S., and shall file the rules and the opinion of the attorney general with the secretary of state pursuant to section 24-4-103 (12), C.R.S., and with the office of legislative legal services. Pursuant to section 24-4-103 (5), C.R.S., the rules shall be effective twenty days after publication of the rules and shall only be effective until the following May 15 unless the rules are extended pursuant to a bill enacted pursuant to section 24-4-103 (8), C.R.S.

(b.5) (I) Notwithstanding any provisions of paragraph (b) of this subsection (5) to the contrary, if revenue from the provider fee is insufficient to fully fund all of the purposes described in paragraph (b) of subsection (4) of this section, revenue from the provider fee shall be used first to offset general fund expenditures for the state medicaid program for state fiscal years 2011-12 and 2012-13 in the amounts set forth in subparagraph (IX) of paragraph (b) of subsection (4) of this section.

(II) This paragraph (b.5) is repealed, effective December 31, 2013.

(c) Notwithstanding any other provision of this section, if, after receipt of authorization to receive federal matching funds for moneys in the fund, the authorization is withdrawn or changed so that federal matching funds are no longer available, the state department shall cease collecting the provider fee and shall repay to the hospitals any moneys received by the fund that are not subject to federal matching funds.

(6) **Hospital provider fee oversight and advisory board.** (a) There is hereby created in the state department the hospital provider fee oversight and advisory board, referred to in this section as the "advisory board".

(b) (I) The advisory board shall consist of thirteen members appointed by the governor, with the advice and consent of the senate, as follows:

(A) Five members who are employed by hospitals in Colorado, including at least one person who is employed by a hospital in a rural area, one person who is employed by a safety-net hospital for which the percent of medicaid-eligible inpatient days relative to its total inpatient days shall be equal to or greater than one standard deviation above the mean, and one person who is employed by a hospital in an urban area;

(B) One member who is a representative of a statewide organization of hospitals;

(C) One member who represents a statewide organization of health insurance carriers or a health insurance carrier licensed pursuant to title 10, C.R.S., and who is not a representative of a hospital;

(D) One member of the health care industry who does not represent a hospital or a health insurance carrier;

(E) One member who is a consumer of health care and who is not a representative or an employee of a hospital, health insurance carrier, or other health care industry entity;

(F) One member who is a representative of persons with disabilities, who is living with a disability, and who is not a representative or an employee of a hospital, health insurance carrier, or other health care industry entity;

(G) One member who is a representative of a business that purchases or otherwise provides health insurance for its employees; and

(H) Two employees of the state department.

(II) The governor shall consult with representatives of a statewide organization of hospitals in making the appointments pursuant to sub-subparagraphs (A) and (B) of subparagraph (I) of this paragraph (b). No more than six members of the advisory board may be members of the same political party.

(III) Members of the advisory board shall serve at the pleasure of the governor. In making the appointments, the governor shall specify that four members shall serve initial terms of two years and three members shall serve initial terms of three years. All other terms including terms after the initial terms shall be four years. A member who is appointed to fill a vacancy shall serve the remainder of the unexpired term of the former member.

(IV) The governor shall designate a chair from among the members of the advisory board appointed pursuant to sub-subparagraphs (A) to (G) of subparagraph (I) of this paragraph (b). The advisory board shall elect a vice-chair from among its members.

(c) Members of the advisory board shall serve without compensation but shall be reimbursed from moneys in the fund for actual and necessary expenses incurred in the performance of their duties pursuant to this section.

(d) The advisory board may direct the state department to contract for a group facilitator to assist the members of the advisory board in performing their required duties.

(e) The advisory board shall have, at a minimum, the following duties:

(I) To recommend to the state department the timing and method by which the state department shall assess the provider fee and the amount of the fee;

(II) If requested by the health and human services committees of the senate or house of representatives, or any successor committees, to consult with the committees on any legislation that may impact the provider fee or hospital reimbursements established pursuant to this section;

(III) To recommend to the state department changes in the provider fee that increase the number of hospitals benefitting from the uses of the provider fee described in subparagraphs (I) to (V) of paragraph (b) of subsection (4) of this section or that minimize the number of hospitals that suffer losses as a result of paying the provider fee;

(IV) To recommend to the state department reforms or changes to the inpatient hospital and outpatient hospital reimbursements and quality incentive payments made under the state medical assistance program to increase provider accountability, performance, and reporting;

(V) To recommend to the state department the schedule and approach to the implementation of subparagraphs (IV) and (V) of paragraph (b) of subsection (4) of this section;

(VI) If moneys in the fund are insufficient to fully fund all of the purposes specified in paragraph (b) of subsection (4) of this section, to recommend to the state board changes to the expanded eligibility provisions described in subparagraph (IV) of paragraph (b) of subsection (4) of this section;

(VII) To prepare the reports specified in paragraph (f) of this subsection (6);

(VIII) To monitor the impact of the hospital provider fee on the broader health care marketplace; and

(IX) To perform any other duties required to fulfill the advisory board's charge or those assigned to it by the state board or the executive director.

(f) On or before January 15, 2010, and on or before January 15 each year thereafter, the advisory board shall submit a written report to the health and human services committees of the senate and the house of representatives, or any successor committees, the joint budget committee of the general assembly, the governor, and the state board. The report shall include, but need not be limited to:

- (I) The recommendations made to the state board pursuant to this section;
- (II) A description of the formula for how the provider fee is calculated and the process by which the provider fee is assessed and collected;
- (III) An itemization of the total amount of the provider fee paid by each hospital and any projected revenue that each hospital is expected to receive due to:
 - (A) The increased reimbursements made pursuant to subparagraphs (I) and (II) of paragraph (b) of subsection (4) of this section and the quality incentive payments made pursuant to subparagraph (III) of paragraph (b) of subsection (4) of this section; and
 - (B) The increased eligibility described in subparagraphs (IV) and (V) of paragraph (b) of subsection (4) of this section;
 - (IV) An itemization of the costs incurred by the state department in implementing and administering the hospital provider fee; and
 - (V) Estimates of the differences between the cost of care provided and the payment received by hospitals on a per-patient basis, aggregated for all hospitals, for patients covered by each of the following:
 - (A) Medicaid;
 - (B) Medicare; and
 - (C) All other payers.
- (g) (I) This subsection (6) is repealed, effective July 1, 2019.
- (II) Prior to said repeal, the advisory board shall be reviewed as provided in section 2-3-1203, C.R.S.
- (7) Repealed.

25.5-4-402.5. Providers - state university teaching hospitals. Subject to appropriations by the general assembly, the state department shall make payments to state university teaching hospitals for providing care under the state's medical assistance program established pursuant to this article and articles 5 and 6 of this title.

25.5-4-403. Providers - community mental health center and clinics - reimbursement. For the purpose of reimbursing community mental health center and clinic providers, the state department shall establish a price schedule annually with the department of human services in order to reimburse each provider for its actual or reasonable cost of services.

25.5-4-404. Payments for clinic services - restrictions on use. All payments received by county or district public health agencies or boards of health for clinic services, as defined in section 25.5-5-301 (3), furnished to patients shall be used only to

offset costs incurred for provision of services by such county or district public health agencies or boards of health or to cash fund health care services in the county where the services were provided.

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 under the medical assistance program shall comply with all federal requirements, including but not limited to:

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

(b) Informing each recipient of his or her 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 and transferring the recipient for appropriate continued services.

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

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

(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 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 is informed of the patient representative program and how a patient representative may be contacted.

25.5-4-406. Rate setting - medicaid residential treatment service providers - monitoring and auditing - report. (1) The state department shall approve a rate-setting process consistent with medicaid requirements for providers of medicaid residential treatment services in the state of Colorado as developed by the department of human services. The rate-setting process developed pursuant to this section may include, but

shall not be limited to:

(a) A range for reimbursement that represents a base-treatment rate for serving a child who is subject to out-of-home placement due to dependency and neglect, a child placed in a residential child care facility pursuant to the "Child Mental Health Treatment Act", article 67 of title 27, C.R.S., or a child who has been adjudicated a delinquent, which includes a defined service package to meet the needs of the child;

(b) A request for proposal to contract for specialized service needs of a child, including but not limited to: Substance-abuse treatment services; sex offender services; and services for the developmentally disabled; and

(c) Negotiated incentives for achieving outcomes for the child as defined by the state department, counties, and providers.

(2) The medicaid rate-setting process approved by the state department shall include a two- or three-year implementation timeline with implementation beginning in state fiscal year 2008-09.

(3) The state department and the department of human services, in consultation with the representatives of the counties and the provider community, shall review the rate-setting process every two years and shall submit any changes to the joint budget committee of the general assembly.

25.5-4-407. Services by licensed psychologists without a doctor's referral. The executive director of the state department may authorize the providing of services of licensed psychologists without the requirement that the services be referred by a doctor of medicine or a doctor of osteopathy, but such services shall be subject to the cost containment program specified under section 25.5-4-408. The executive director may except from the authorization those services the director determines to be necessary for the purpose of promoting the primary care physician program.

25.5-4-408. Services provided by licensed psychologists - cost containment program. (1) Working in conjunction with licensed psychologists in the state, the state board shall promulgate rules to establish and implement mechanisms for containing the costs of services provided by licensed psychologists under the medical assistance programs established pursuant to this article and articles 5 and 6 of this title. The cost containment mechanism shall ensure that the costs to the medical assistance program will result in no increase in the total cost of the program solely as a result of the reimbursement for services of licensed psychologists pursuant to section 25.5-4-407. The cost containment mechanisms may include the following:

(a) Limiting the number of days a licensed psychologist may be reimbursed per patient for inpatient hospitalization, partial hospitalization, and outpatient visits without

an order for continued treatment from a doctor of medicine or osteopathy;

(b) Limiting the number of hours a licensed psychologist may be reimbursed for diagnostic testing and evaluation per patient per year;

(c) Provision of group therapy when needed or appropriate;

(d) Provision of licensed psychologists' services from a pool of those licensed psychologists requesting to be included in such pool;

(e) Provision of a licensed psychologist's services through the use of telemedicine pursuant to the provisions of section 25.5-5-320.

25.5-4-409. Authorization of services - nurse anesthetists - advanced practice nurses. (1) When services by a certified registered nurse anesthetist are provided pursuant to an order by a physician in accordance with this article, articles 5 and 6 of this title, and section 12-38-103 (10), C.R.S., the executive director of the state department shall authorize reimbursement for said services. Payment for such services shall be made directly to the nurse anesthetist, if requested by the nurse anesthetist; except that this section shall not apply to nurse anesthetists when acting within the scope of their employment as salaried employees of public or private institutions or physicians.

(2) When services by an advanced practice nurse registered pursuant to section 12-38-111.5, C.R.S., are provided in accordance with this article and articles 5 and 6 of this title, the executive director of the state department shall authorize reimbursement for said services. Payment for the services shall be made directly to the advanced practice nurse, if requested by the advanced practice nurse; except that this section shall not apply to advanced practice nurses when acting within the scope of their employment as salaried employees of public or private institutions or physicians.

25.5-4-410. Services of audiologists and speech pathologists without supervision. (1) When medical or diagnostic services by an audiologist or speech pathologist are provided pursuant to an order by a physician in accordance with this article and articles 5 and 6 of this title, the executive director of the state department shall authorize reimbursement for said services. For the purposes of this section, "audiologist" or "speech pathologist" means an individual who meets the requirements set forth in the federal "Social Security Act", as amended, or any federal regulations adopted pursuant thereto, for participating providers of audiology or speech pathology services.

(2) Nothing in this section shall be construed as expanding the provision of services available as a part of the medical assistance program established pursuant to this article and articles 5 and 6 of this title. For the purposes of making payments to audiologists or speech pathologists pursuant to this section, the state board shall establish rules implementing this section. The rules promulgated pursuant to this subsection (2)

shall ensure that the costs to the medical assistance program will result in no increase in the total cost of the program solely as a result of the reimbursement for services of an audiologist or speech pathologist pursuant to this section.

(3) Payments for services included in this section shall be made directly to the audiologist or speech pathologist, if requested by the audiologist or speech pathologist; except that this section shall not apply to audiologists or speech pathologists when acting within the scope of their employment as salaried employees of public or private institutions or physicians.

25.5-4-411. Authorization of services provided by dental hygienists. (1) When dental hygiene services are provided to children by a licensed dental hygienist who is providing dental hygiene services pursuant to section 12-35-124, C.R.S., without the supervision of a licensed dentist, the executive director of the state department shall authorize reimbursement for said services, subject to the requirements of this section. Payment for such services shall be made directly to the licensed dental hygienist, if requested by the licensed dental hygienist; except that this section shall not apply to licensed dental hygienists when acting within the scope of their employment as salaried employees of public or private institutions, physicians, or dentists.

(2) For each child provided dental hygiene services pursuant to this section, the dental hygienist shall attempt to identify a dentist participating in medicaid for the child.

25.5-4-412. Medical services provided by certified family planning clinics. (1) When medical or diagnostic services are provided in accordance with this article and articles 5 and 6 of this title by a certified family planning clinic, the executive director of the state department shall authorize reimbursement for the services. The reimbursement shall be made directly to the certified family planning clinic.

(2) For purposes of this section, "certified family planning clinic" means a family planning clinic certified by the Colorado department of public health and environment, accredited by a national family planning organization, and staffed by medical professionals licensed to practice in the state of Colorado, including, but not limited to, doctors of medicine, doctors of osteopathy, physicians' assistants, and advanced practice nurses.

(3) For purposes of this section, all medical care services or goods rendered by a certified family planning clinic that are benefits of the Colorado medical assistance program shall be ordered by a physician who need not be physically present on the premises of the certified family planning clinic at the time services are rendered.

(4) Nothing in this section shall be construed as expanding the provision of services available as a part of the medical assistance program established pursuant to this

article and articles 5 and 6 of this title. For purposes of making payments to certified family planning clinics pursuant to this section, the state board shall establish rules implementing this section. The rules promulgated pursuant to this subsection (4) shall ensure that the reimbursement for services rendered by a certified family planning clinic pursuant to this section shall not be the sole result of an increase in the costs to the state medical assistance program.

25.5-4-413. Certain providers to inform patients of rights concerning advance medical directives. (1) On and after November 5, 1991, with regard to any service rendered on and after said date, each hospital, nursing care facility, home health agency, hospice program, and health maintenance organization participating in the state medical assistance program or providing medical assistance pursuant to parts 3 to 12 of article 6 of this title shall provide written information to all adult patients of such providers concerning patients' rights under state law to make medical treatment decisions, including the right to accept or refuse any medical or surgical treatment and the right to formulate advance directives regarding said decisions. As used in this section, "advance directives" includes any written or oral instructions recognized under state law concerning the making of medical treatment decisions on behalf of or the provision of medical care for the person who provided the instructions in the event such person becomes incapacitated. Advance directives include, but are not limited to, medical durable powers of attorney, durable powers of attorney, or living wills.

(2) Providers listed in subsection (1) of this section shall provide educational programs for staff and the community concerning advance directives and shall maintain written policies detailing methods for safeguarding patients' rights concerning medical treatment decisions, including documenting in the patient's medical or patient record whether the patient has executed, amended, or revoked an advance directive. No provider shall condition the provision of services or otherwise discriminate against a patient on the basis of whether the patient has executed an advance directive.

25.5-4-414. Providers - physicians - prohibition of certain referrals - definitions. (1) As used in this section, unless the context otherwise requires:

(a) "Designated health services" means any of the following services:

- (I) Clinical laboratory services;
- (II) Physical therapy services;
- (III) Occupational therapy services;
- (IV) Radiology and other diagnostic services;
- (V) Radiation therapy services;
- (VI) Durable medical equipment;

- (VII) Parenteral or enteral nutrients, equipment, and supplies;
- (VIII) Prosthetics, orthotics, and prosthetic devices;
- (IX) Home health services;
- (X) Outpatient prescription drugs; and
- (XI) Inpatient and outpatient hospital services.

(b) "Financial relationship" means an ownership or investment interest in an entity furnishing designated health services or a compensation arrangement between a provider or an immediate family member of the provider and the entity. An ownership or investment interest may be reflected in equity, debt, or other instruments.

(c) "Immediate family member of the provider" means any spouse, natural or adoptive parent, natural or adoptive child, stepparent, stepchild, stepbrother, stepsister, in-law, grandparent, or grandchild of the provider.

(d) "Provider" means:

(I) A doctor of medicine or osteopathy who is licensed to practice medicine pursuant to article 36 of title 12, C.R.S.;

(II) A doctor of dental surgery or of dental medicine who is licensed to practice dentistry pursuant to article 35 of title 12, C.R.S.;

(III) A doctor of podiatric medicine who is licensed to practice podiatry pursuant to article 32 of title 12, C.R.S.;

(IV) A doctor of optometry who is licensed to practice optometry pursuant to article 40 of title 12, C.R.S.; or

(V) A chiropractor who is licensed to practice chiropractic pursuant to article 33 of title 12, C.R.S.

(2) (a) Except as otherwise provided in this subsection (2), a provider participating in the medical assistance program under this article and articles 5 and 6 of this title is prohibited from making a referral to an entity for designated health services for which payment may be made under the state's medical assistance program if the provider or an immediate family member of the provider has a financial relationship with the entity.

(b) Paragraph (a) of this subsection (2) shall not apply to any financial relationship that meets the requirements of an exception to the prohibitions established by 42 U.S.C. sec. 1395nn, as amended, or any regulations promulgated thereunder, as amended.

(c) Paragraph (a) of this subsection (2) shall not apply to a financial relationship or referral for designated health services if the financial relationship or referral for designated health services would not violate 42 U.S.C. sec. 1395nn, as amended, and any regulations promulgated thereunder, as amended, if the designated health services were eligible for payment under medicare rather than the "Colorado Medical Assistance Act".

(3) An entity that provides designated health services as a result of a prohibited referral shall not present a claim or bill to any individual, any third-party payor, the state department, or any other entity for the designated health services.

(4) An entity that provides designated health services shall provide to the state

department, upon its request and in the form specified by the state department, information concerning the entity's ownership arrangements including:

- (a) The items and services provided by the entity;
- (b) The names and provider identification numbers of all providers with a financial interest in the entity or whose immediate family members have a financial interest in the entity.

(5) If a provider refers a patient for designated health services in violation of paragraph (a) of subsection (2) of this section or the entity refuses to provide the information required in subsection (4) of this section, the state department may:

- (a) Deny any claims for payment from the provider or entity;
- (b) Require the provider or entity to refund payments for services;
- (c) Refer the matter to the appropriate agency for medical assistance fraud investigation; or
- (d) Terminate the provider's or entity's participation in the medical assistance program.

25.5-4-415. No public funds for abortion - exception - repeal. (1) It is the purpose of this section to implement the provisions of section 50 of article V of the Colorado constitution, adopted by the registered electors of the state of Colorado at the general election November 6, 1984, which prohibits the use of public funds by the state of Colorado or its agencies or political subdivisions to pay or otherwise reimburse, directly or indirectly, any person, agency, or facility for any induced abortion.

(2) If every reasonable effort has been made to preserve the lives of a pregnant woman and her unborn child, then public funds may be used pursuant to this section to pay or reimburse for necessary medical services, not otherwise provided for by law.

(3) (a) Except as provided in paragraph (b) of this subsection (3), any necessary medical services performed pursuant to this section shall be performed only in a licensed health care facility by a provider who is a licensed physician.

(b) However, such services may be performed in other than a licensed health care facility if, in the medical judgment of the attending physician, the life of the pregnant woman or her unborn child is substantially threatened and a transfer to a licensed health care facility would further endanger the life of the pregnant woman or her unborn child. Such medical services may be performed in other than a licensed health care facility if the medical services are necessitated by a life-endangering circumstance described in subparagraph (II) of paragraph (b) of subsection (6) of this section and if there is no licensed health care facility within a thirty-mile radius of the place where such medical services are performed.

(4) (a) Any physician who renders necessary medical services pursuant to subsection (2) of this section shall report the following information to the state

department:

(I) The age of the pregnant woman and the gestational age of the unborn child at the time the necessary medical services were performed;

(II) The necessary medical services which were performed;

(III) The medical condition which necessitated the performance of necessary medical services;

(IV) The date such necessary medical services were performed and the name of the facility in which such services were performed.

(b) The information required to be reported pursuant to paragraph (a) of this subsection (4) shall be compiled by the state department and such compilation shall be an ongoing public record; except that the privacy of the pregnant woman and the attending physician shall be preserved.

(5) For purposes of this section, pregnancy is a medically diagnosable condition.

(6) For the purposes of this section:

(a) (I) "Death" means:

(A) The irreversible cessation of circulatory and respiratory functions; or

(B) The irreversible cessation of all functions of the entire brain, including the brain stem.

(II) A determination of death under this section shall be in accordance with accepted medical standards.

(b) "Life-endangering circumstance" means:

(I) The presence of a medical condition, other than a psychiatric condition, as determined by the attending physician, which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy continues to term;

(II) The presence of a lethal medical condition in the unborn child, as determined by the attending physician and one other physician, which would result in the impending death of the unborn child during the term of pregnancy or at birth; or

(III) The presence of a psychiatric condition which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy continues to term. In such case, unless the pregnant woman has been receiving prolonged psychiatric care, the attending licensed physician shall obtain consultation from a licensed physician specializing in psychiatry confirming the presence of such a psychiatric condition. The attending physician shall report the findings of such consultation to the state department.

(c) "Necessary medical services" means any medical procedures deemed necessary to prevent the death of a pregnant woman or her unborn child due to life-endangering circumstances.

(7) If any provision of this section or application thereof is held invalid, such invalidity shall not affect other provisions or applications of this section which can be given effect without the invalid provision or application, and to this end the provisions of this section are declared severable.

(8) Use of the term "unborn child" in this section is solely for the purposes of facilitating the implementation of section 50 of article V of the state constitution, and its use shall not affect any other law or statute nor shall it create any presumptions relating to the legal status of an unborn child or create or affect any distinction between the legal status of an unborn child and the legal status of a fetus.

(9) This section shall be repealed if section 50 of article V of the Colorado constitution is repealed.

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.

(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) (I) Has one or more physical locations within the state of Colorado or within fifty miles of a border of Colorado with a street address, a local business telephone number, an inventory, and a sufficient staff to service or repair products; except that the requirements of this paragraph (a) shall not apply to durable medical equipment or disposable medical supplies that are medically necessary and cannot be purchased from a provider meeting the requirements of this paragraph (a);

(II) Complies with all state and local licensing, insurance, and regulatory requirements for operating the provider's business;

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

(IV) Provides repairs, replacements, or adjustments to the provider's products pursuant to rules of the state board; or

(b) Contracts with a provider who meets the criteria established in paragraph (a) of this subsection (2).

(3) The provisions of this section shall apply to fee-for-service and primary care physician program recipients.

25.5-4-417. Provider fee - medicaid providers - state plan amendment - rules - definitions. (1) For purposes of this section, unless the context otherwise requires:

(a) "Local government" means a county, home rule county, home rule or statutory city, town, territorial charter city, or city and county.

(b) "Provider fee" means a licensing fee, assessment, or other mandatory payment

that is related to health care items or services as specified under 42 CFR 433.55.

(c) "Qualified provider" means a hospital licensed pursuant to section 25-3-101, C.R.S., or a certified home health care agency within the territorial boundaries of the local government.

(2) For the purpose of sustaining or increasing reimbursement for providing medical care under the state's medical assistance program and to low-income populations, the state department shall amend the state plan effective July 1, 2006. Implementation of the state plan amendment shall be subject to the approval of the federal government. The imposition and collection of a provider fee by a local government pursuant to article 28 of title 29, C.R.S., shall be prohibited without the federal government's approval of a state plan amendment authorizing federal financial participation for the provider fees.

(3) In accordance with the redistributive method set forth in 42 CFR 433.68 (e) (1) and (e) (2), the state department may seek a waiver from the broad-based provider fee requirement or the uniform provider fee requirement, or both, to exclude qualified providers from the provider fee.

(4) To the extent authorized by federal law, the state department may exclude a governmental qualified provider from payment of the provider fee, benefits from the provider fee, or any federal financial participation due to the fee.

(5) To the extent authorized by federal law, the state department shall distribute the provider fee and any associated federal financial participation either to a local government that has certified payment to qualified providers within the local government or directly to the qualified providers. The state department shall establish reimbursement methods to distribute the provider fee and associated federal financial participation to qualified providers. The state department may alter reimbursement methods to qualified providers participating under the state's medical assistance program and Colorado indigent care program to the extent necessary to meet the federal requirements and to obtain federal approval of the provider fee. The state department shall work with a statewide association of hospitals on changes to reimbursement methods or provider fees that impact hospital providers. The state department shall work with a statewide association of home health care agencies on changes to reimbursement methods or provider fees that impact home health care agencies.

(6) The state board shall adopt any rules necessary for the administration and implementation of this section.

25.5-4-418. Integration of physical and behavioral health services - department review - report - repeal. (Repealed)

PART 5

STATE PLAN AMENDMENTS -
WAIVER AUTHORITY

25.5-4-501. State plan amendment - federal authorization - repeal. (Repealed)

25.5-4-502. Federal authorization - repeal. (Repealed)

25.5-4-503. Waiver applications - authorization. The state department is authorized to apply for health insurance flexibility and accountability waivers that will enable the state to add more flexibility to Colorado's medicaid program and that will result in a cost-effective method of providing health care services to Coloradans.

ARTICLE 5

Colorado Medical Assistance Act -
Services and Programs

PART 1

MANDATORY PROVISIONS

25.5-5-101. Mandatory provisions - eligible groups. (1) In order to participate in the medicaid program, the federal government requires the state to provide medical assistance to certain eligible groups. Pursuant to federal law and except as provided in subsection (2) of this section, any person who is eligible for medical assistance under the mandated groups specified in this section shall receive both the mandatory services that are specified in sections 25.5-5-102 and 25.5-5-103 and the optional services that are specified in sections 25.5-5-202 and 25.5-5-203. Subject to the availability of federal financial participation, the following are the individuals or groups that are mandated under federal law to receive benefits under this article and articles 4 and 6 of this title:

(a) Individuals who meet the eligibility criteria for the aid to families with dependent children program pursuant to rules that were in effect on July 16, 1996;

(b) Families who meet the eligibility criteria for the aid to families with dependent children program established in rules that were in effect on July 16, 1996, and who

subsequently would have become ineligible under such eligibility criteria because of increased earnings or increased hours of employment whose eligibility is specified for a period of time by the federal government;

(c) Qualified pregnant women, and children under the age of seven, who meet the income requirements of the state's aid to families with dependent children program pursuant to rules that were in effect on July 16, 1996;

(d) A newborn child born of a woman who is categorically needy. Such child is deemed medicaid-eligible on the date of birth and remains eligible for one year so long as the woman remains categorically needy and the child is a member of her household.

(e) Children for whom adoption assistance or foster care maintenance payments are made under Title IV-E of the "Social Security Act", as amended;

(f) Individuals receiving supplemental security income;

(g) Individuals receiving mandatory state supplement, including but not limited to individuals receiving old age pensions;

(h) Institutionalized individuals who were eligible for medical assistance in December 1973;

(i) Individuals who would be eligible except for the increase in old-age, survivors, and disability insurance under Pub.L. 92-336;

(j) Individuals who become ineligible for cash assistance as a result of old-age, survivors, and disability insurance cost-of-living increases after April 1977;

(k) Disabled widows or widowers fifty through sixty years of age who have become ineligible for federal supplemental security income or state supplementation as a result of becoming eligible for federal social security survivor's benefits, in accordance with the social security act, 42 U.S.C. sec. 1383c;

(l) Individuals with income and resources at a level which qualifies them as medicare-eligible under section 301 of Title III of the federal "Medicare Catastrophic Coverage Act";

(m) Low-income pregnant women, and children through the age of six, whose income is at or below a certain percentage of the federal poverty line as determined by the federal government.

(2) (a) A qualified alien who entered the United States before August 22, 1996, who meets the exceptions described in the federal "Personal Responsibility and Work Opportunity Reconciliation Act of 1996", Public Law 104-193, as amended, shall receive benefits under this article and articles 4 and 6 of this title.

(b) (I) A qualified alien who entered the United States on or after August 22, 1996, shall not be eligible for benefits under this article or article 4 or 6 of this title, except as provided in section 25.5-5-103 (3), for five years after the date of entry into the United States unless he or she meets the exceptions described in the federal "Personal Responsibility and Work Opportunity Reconciliation Act of 1996", Public Law 104-193, as amended.

(II) Notwithstanding the five-year waiting period established in subparagraph (I) of this paragraph (b), but subject to the availability of sufficient appropriations and the receipt of federal financial participation, the state department may provide benefits under this article and articles 4 and 6 of this title to a pregnant woman who is a qualified alien and a child under nineteen years of age who is a qualified alien so long as such woman or child meets eligibility criteria other than citizenship.

(3) Notwithstanding any other provision of this article and articles 4 and 6 of this title, as a condition of eligibility for medical assistance under this article and articles 4 and 6 of this title, a legal immigrant shall agree to refrain from executing an affidavit of support for the purpose of sponsoring an alien on or after July 1, 1997, under rules promulgated by the immigration and naturalization service, or any successor agency, during the pendency of such legal immigrant's receipt of medical assistance. Nothing in this subsection (3) shall be construed to affect a legal immigrant's eligibility for medical assistance under this article and articles 4 and 6 of this title based upon such legal immigrant's responsibilities under an affidavit of support entered into before July 1, 1997.

(4) (a) An asset test shall not be applied as a condition of eligibility for individuals or families described in paragraphs (a), (b), and (c) of subsection (1) of this section.

(b) Repealed.

(c) Subject to the receipt of any necessary federal approval and pursuant to 42 U.S.C. sec. 1396a (r) (2) and 42 U.S.C. sec. 1396u-1 (b) (2) (C), for the groups described in paragraphs (a) to (c) of subsection (1) of this section, the state board shall develop an income- and resource-counting method to replace the method used under the aid to families with dependent children program pursuant to rules that were in effect on July 16, 1996. The income- and resource-counting method shall be:

(I) No more restrictive than the method used under the aid to families with dependent children program pursuant to the rules that were in effect on July 16, 1996; and

(II) No less restrictive than the method used to determine eligibility for other covered groups under subsection (1) of this section and sections 25.5-5-201, 25.5-5-204, 25.5-5-204.5, and 25.5-5-205.

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 include the following services as mandated and defined by federal law:

- (a) Inpatient hospital services;
- (b) Outpatient hospital services;
- (c) Other laboratory and X-ray services;
- (d) Physicians' services, wherever furnished;
- (e) Nursing facility services;

- (f) Home health services;
- (g) Early and periodic screening, diagnosis, and treatment, as required by federal law;
- (h) Family planning;
- (i) Rural health services;
- (j) Advanced practice nurse services;
- (k) and (l) (Deleted by amendment, L. 2008, p. 138, § 2, effective July 1, 2008.)
- (m) Federally qualified health centers.

(2) In order to keep expenditures within approved appropriations, the state board may, by rule, establish limits on a service provided pursuant to this section so long as the service provided is sufficient in the amount, duration, and scope to reasonably achieve the purpose of the service as required by federal law or regulation. When a rule is promulgated pursuant to this subsection (2), the state board shall provide a summary report of the limitations established by the rule and any fiscal impact of the rule to members of the health and human services committees of the senate and house of representatives, or any successor committees, and any other members of the general assembly who request the reports.

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

- (a) The program known as the baby and kid care program which provides medical assistance for pregnant women and children, as specified in section 25.5-5-205;
- (b) Special provisions relating to nursing facilities, as specified in sections 25.5-6-201 to 25.5-6-203, 25.5-6-205, and 25.5-6-206;
- (c) The program for qualified medicare beneficiaries, as specified in section 25.5-5-104;
- (d) The program for qualified disabled and working individuals, as specified in section 25.5-5-105;
- (e) Special provisions for the purchase of group health insurance for recipients, as specified in section 25.5-4-210;
- (f) The program to provide health services to students by school districts as specified in section 25.5-5-318.

(2) The medical assistance program also is subject to special provisions relating to the use of public funds for abortion which are required by section 50 of article V of the Colorado constitution. Those special provisions are specified in section 25.5-4-415.

(3) (a) Emergency medical assistance shall be provided to any person who is not a citizen of the United States, including undocumented aliens, aliens who are not qualified aliens, and qualified aliens who entered the United States on or after August 22, 1996,

who has an emergency medical condition and meets one of the categorical requirements set forth in section 25.5-5-101; except that such persons shall not be required to meet any residency requirement other than that required by federal law.

(b) The state board shall adopt rules necessary for the implementation of this subsection (3), including in such rules definitions of "emergency services", "emergency medical condition", "geographic area", and "prenatal care".

25.5-5-104. Qualified medicare beneficiaries. Qualified medicare beneficiaries are medicare-eligible individuals with income and resources at a level which qualifies them as eligible under section 301 of Title III of the federal "Medicare Catastrophic Coverage Act of 1988", as amended, or subsequent amending federal legislation. For purposes of this article and articles 4 and 6 of this title, such individuals shall be referred to as "qualified medicare beneficiaries". The state department is hereby designated as the single state agency to administer benefits available to qualified medicare beneficiaries in accordance with Title XIX and this article and articles 4 and 6 of this title. Such benefits are limited to medicare cost-sharing expenses as determined by the federal government. Accordingly, the state department shall not be required to provide qualified medicare beneficiaries the entire range of services set forth in section 25.5-5-102.

25.5-5-105. Qualified disabled and working individuals. Qualified disabled and working individuals are persons with income and resources and disability status, as determined by the social security administration, which qualify them as "qualified disabled and working individuals" under sections 6012 and 6408 of the federal "Omnibus Budget Reconciliation Act of 1989", or subsequent amending federal legislation. The state department is hereby designated as the single state agency to administer benefits available to qualified disabled and working individuals. Such benefits are limited to medicare cost-sharing expenses as determined by the federal government. Accordingly, the state department shall not be required to provide qualified disabled and working individuals the entire range of services set forth in section 25.5-5-102.

PART 2

OPTIONAL PROVISIONS

25.5-5-201. Optional provisions - optional groups - repeal. (1) The federal government allows the state to select optional groups to receive medical assistance. Pursuant to federal law, any person who is eligible for medical assistance under the

optional groups specified in this section shall receive both the mandatory services specified in sections 25.5-5-102 and 25.5-5-103 and the optional services specified in sections 25.5-5-202 and 25.5-5-203. Subject to the availability of federal financial aid funds, the following are the individuals or groups that Colorado has selected as optional groups to receive medical assistance pursuant to this article and articles 4 and 6 of this title:

- (a) Individuals who would be eligible for but are not receiving cash assistance;
- (b) Individuals who would be eligible for cash assistance except for their institutionalized status;
- (c) Individuals receiving home- and community-based services as specified in article 6 of this title;
- (d) Individuals who would be eligible for aid to families with dependent children if child care were paid from earnings;
- (e) Individuals under the age of twenty-one who would be eligible for aid to families with dependent children but do not qualify as dependent children;
- (f) Individuals receiving only optional state supplement;
- (g) Individuals in institutions who are eligible under a special income level. Colorado's program for citizens sixty-five years of age or older or physically disabled or blind, whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, qualifies for federal funding under this provision.
- (h) Persons who are eligible for cash assistance under the works program pursuant to section 26-2-706, C.R.S.;
- (i) Persons who are eligible for the breast and cervical cancer prevention and treatment program pursuant to section 25.5-5-308;
- (j) Individuals who are qualified aliens and were or would have been eligible for supplemental security income as a result of a disability but are not eligible for such supplemental security income as a result of the passage of the federal "Personal Responsibility and Work Opportunity Reconciliation Act of 1996", Public Law 104-193;
- (k) Other qualified aliens who entered or were present in the United States before August 22, 1996;
- (l) Children for whom subsidized adoption assistance payments are made by the state pursuant to article 7 of title 26, C.R.S., or foster care maintenance payments are made by the state pursuant to article 5 of title 26, C.R.S., but who do not meet the requirements of Title IV-E of the "Social Security Act", as amended;
- (m) Parents and caretaker relatives of children who are eligible for the medical assistance program whose family income does not exceed one hundred thirty-three percent of the federal poverty line, adjusted for family size;
- (n) Individuals under the age of twenty-one years eligible for medical assistance pursuant to paragraph (l) of this subsection (1) or section 25.5-5-101 (1) (e) immediately

prior to attaining the age of eighteen years or otherwise becoming emancipated;

(o) (I) Individuals with disabilities who are participating in the medicaid buy-in program established in part 14 of article 6 of this title.

(II) Notwithstanding the provisions of subparagraph (I) of this paragraph (o), if the moneys in the hospital provider fee cash fund established pursuant to section 25.5-4-402.3 (4), together with the corresponding federal matching funds, are insufficient to fully fund all of the purposes described in section 25.5-4-402.3 (4) (b), after receiving recommendations from the hospital provider fee oversight and advisory board established pursuant to section 25.5-4-402.3 (6), for individuals with disabilities who are participating in the medicaid buy-in program established in part 14 of article 6 of this title, the state board by rule adopted pursuant to the provisions of section 25.5-4-402.3 (5) (b) (III) may reduce the medical benefits offered or the percentage of the federal poverty line to below four hundred fifty percent or may eliminate this eligibility group.

(III) Repealed.

(p) Subject to federal approval, adults who are childless or without a dependent child in the home, as described in section 1902 (a) (10) (A) (i) (VIII) of the social security act, 42 U.S.C. sec. 1396a, who have attained nineteen years of age but have not attained sixty-five years of age, and whose family income does not exceed one hundred thirty-three percent of the federal poverty line, adjusted for family size;

(q) Children who are continuously eligible for twelve months pursuant to section 25.5-5-204.5;

(r) (I) Persons eligible for a medicaid buy-in program established pursuant to section 25.5-5-206 whose family income does not exceed a specified percentage of the federal poverty line, adjusted for family size and as set by the state board by rule, which percentage shall be not more than four hundred fifty percent.

(II) Notwithstanding the provisions of subparagraph (I) of this paragraph (r), if the moneys in the hospital provider fee cash fund established pursuant to section 25.5-4-402.3 (4), together with the corresponding federal matching funds, are insufficient to fully fund all of the purposes described in section 25.5-4-402.3 (4) (b), after receiving recommendations from the hospital provider fee oversight and advisory board established pursuant to section 25.5-4-402.3 (6), for persons eligible for a medicaid buy-in program established pursuant to section 25.5-5-206, the state board by rule adopted pursuant to the provisions of section 25.5-4-402.3 (5) (b) (III) may reduce the medical benefits offered, or the percentage of the federal poverty line, or may eliminate this eligibility group.

(III) (A) Notwithstanding the provision of subparagraph (I) of this paragraph (r), persons eligible for a medicaid buy-in program established pursuant to section 25.5-5-206 shall only be eligible for benefits under the medical assistance program if the state department receives federal authorization for such eligibility.

(B) Within sixty days after the state department receives authorization to provide medical benefits to persons eligible for a medicaid buy-in program established pursuant to

section 25.5-5-206, the executive director shall send written notice to the revisor of statutes informing him or her of the authorization.

(C) This subparagraph (III) is repealed, effective the July 1 following the receipt of the notice to the revisor of statutes.

(2) (a) A qualified alien, who entered the United States on or after August 22, 1996, shall not be eligible for benefits under this article and articles 4 and 6 of this title, except as provided in section 25.5-5-103 (3), for five years after the date of entry into the United States unless he or she meets the exceptions described in the federal "Personal Responsibility and Work Opportunity Reconciliation Act of 1996", Public Law 104-193, as amended. After five years, such qualified alien shall be eligible for benefits under this article and articles 4 and 6 of this title but shall have sponsor income and resources deemed to the individual or family under rules established by the state board of human services pursuant to section 26-2-137, C.R.S.

(b) Notwithstanding the five-year waiting period established in paragraph (a) of this subsection (2), but subject to the availability of sufficient appropriations and the receipt of federal financial participation, the state department may provide benefits under this article and articles 4 and 6 of this title to a pregnant woman who is a qualified alien and a child under nineteen years of age who is a qualified alien so long as such woman or child meets eligibility criteria other than citizenship.

(3) A legal immigrant who is receiving medicaid nursing facility care or home- and community-based services on July 1, 1997, shall continue to receive such services as long as he or she meets the eligibility requirements other than citizen status. State general funds may be used to reimburse such care in the event that federal financial participation is not available.

(4) A pregnant legal immigrant shall be eligible to receive prenatal and medical services for labor and delivery as long as she meets eligibility requirements other than citizen status. State general funds may be used to reimburse such care in the event that federal financial participation is not available.

(5) (a) An asset test shall not be applied as a condition of eligibility for individuals or families described in paragraphs (a), (h), and (m) of subsection (1) of this section.

(b) Repealed.

(c) Subject to the receipt of any necessary federal approval and pursuant to 42 U.S.C. sec. 1396a (r) (2) and 42 U.S.C. sec. 1396u-1 (b) (2) (C), for the groups described in paragraphs (d) and (e) of subsection (1) of this section, the state board shall develop an income- and resource-counting method to replace the method used under the aid to families with dependent children program pursuant to rules that were in effect on July 16, 1996. The income- and resource-counting method shall be:

(I) No more restrictive than the method used under the aid to families with dependent children program pursuant to the rules that were in effect on July 16, 1996; and

(II) No less restrictive than the method used to determine eligibility for other

covered groups under subsection (1) of this section and sections 25.5-5-101, 25.5-5-204, 25.5-5-204.5, and 25.5-5-205.

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

(a) (I) Prescribed drugs.

(II) Notwithstanding the provisions of subparagraph (I) of this paragraph (a), pursuant to the provisions of section 25.5-5-503, prescribed drugs shall not be a covered benefit under the medical assistance program for a recipient 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.

(a.5) Over-the-counter medications, as specified in section 25.5-5-322;

(b) Clinic services, as defined in sections 25.5-5-301 and 25.5-5-302;

(c) Home- and community-based services, as specified in article 6 of this title, which include:

(I) Home- and community-based services for elderly, blind, and disabled persons, as specified in part 3 of article 6 of this title;

(II) Home- and community-based services for developmentally disabled persons, as specified in part 4 of article 6 of this title;

(III) Home- and community-based services for persons living with AIDS, as specified in part 5 of article 6 of this title;

(IV) Home- and community-based services for persons with major mental illnesses, as specified in part 6 of article 6 of this title;

(V) Home- and community-based services for persons with brain injury, as specified in part 7 of article 6 of this title;

(d) Optometrist services;

(e) Eyeglasses when necessary after surgery;

(f) Prosthetic devices, including medically necessary augmentative communication devices; except that nonsurgically implanted prosthetic devices shall be included only after July 1, 1998, and only if the general assembly approves appropriations for these devices as a new benefit;

(g) Rehabilitation services as appropriate to community mental health centers;

(h) Intermediate care facilities for individuals with intellectual disabilities;

(i) Inpatient psychiatric services for persons under twenty-one years of age;

- (j) Inpatient psychiatric services for persons over the age of sixty-five;
- (k) Case management;
- (l) Therapies under home health services, including:
 - (I) Speech and audiology;
 - (II) Physical;
 - (III) Occupational;
- (m) Services of a licensed psychologist;
- (n) Private duty nursing services;
- (o) Podiatry services;
- (p) Hospice care;
- (q) The program of all-inclusive care for the elderly;
- (r) For any pregnant woman who is enrolled or eligible for services pursuant to section 25.5-5-101 (1) (c) or 25.5-5-205, alcohol and drug and addiction counseling and treatment, including outpatient and residential care but not including room and board while receiving residential care;
- (s) (I) Outpatient substance abuse treatment.
 - (II) On or before March 31, 2011, pursuant to section 25.5-5-313 (2), if the legislative audit committee adopts a resolution finding that providing outpatient substance abuse treatment has resulted in an overall increase in costs to the medical assistance program, this paragraph (s) is repealed, effective July 1, 2011.
- (t) Cervical cancer immunization for all females under twenty years of age;
- (u) (I) Screening, brief intervention, and referral to treatment for individuals at risk of substance abuse, including referral to the appropriate level of intervention and treatment.
 - (II) Notwithstanding the provisions of subparagraph (I) of this paragraph (u), services relating to screening, brief intervention, and referral to treatment shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation for the costs of such services.
- (v) (I) Counseling by primary care providers and other specialty providers caring for persons with serious, chronic, or terminal illness relating to medical orders for scope of treatment, which counseling may be reimbursed.
 - (II) Notwithstanding the provisions of subparagraph (I) of this paragraph (v), counseling relating to medical orders for scope of treatment shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation for the costs of such services.
- (w) Dental services for adults.
 - (2) In addition to the services described in subsection (1) of this section and subject to continued federal financial participation, Colorado has selected to provide transportation services as an administrative cost.
 - (3) In order to keep expenditures within approved appropriations, the state board

may, by rule, establish limits on a service provided pursuant to this section so long as the service provided is sufficient in the amount, duration, and scope to reasonably achieve the purpose of the service as required by federal law or regulation. When a rule is promulgated pursuant to this subsection (3), the state board shall provide a summary report of the limitations established by the rule and any fiscal impact of the rule to members of the health and human services committees of the senate and house of representatives, or any successor committees, and any other members of the general assembly who request the reports.

25.5-5-203. Optional programs with special state provisions. (1) Subject to the provisions of subsection (2) of this section, this section specifies programs developed by Colorado to increase federal financial participation through selecting optional services or optional eligible groups. These programs include but are not limited to:

- (a) Pharmaceutical services, as specified in section 25.5-5-504;
- (b) The home- and community-based services program for the elderly, blind, and disabled, as specified in part 3 of article 6 of this title;
- (c) The home- and community-based services program for the developmentally disabled, as specified in part 4 of article 6 of this title;
- (d) The home- and community-based services program for persons living with AIDS, as specified in part 5 of article 6 of this title;
- (e) The home- and community-based services program for persons with major mental illnesses, as specified in part 6 of article 6 of this title;
- (f) The home- and community-based services program for persons with brain injury, as specified in part 7 of article 6 of this title;
- (g) Clinic services, as defined in sections 25.5-5-301 and 25.5-5-302;
- (h) The program for private duty nursing, as specified in section 25.5-5-303;
- (i) The disabled children care program, as specified in section 25.5-6-901;
- (j) The program of all-inclusive care for the elderly, as specified in section 25.5-5-412;
- (k) Hospice care, as specified in section 25.5-5-304;
- (l) The treatment program for high-risk pregnant women, as specified in section 27-80-112, C.R.S., and sections 25.5-5-309, 25.5-5-310, and 25.5-5-311;
- (m) The program for residential child health care, as specified in section 25.5-5-306;
- (n) The children's personal assistance services and family support waiver program, as specified in section 25.5-6-902;
- (o) Home- and community-based services for children with autism, as specified in part 8 of article 6 of this title.

(2) In order to keep expenditures within approved appropriations, the state board

may, by rule, establish limits on a service provided pursuant to this section so long as the service provided is sufficient in the amount, duration, and scope to reasonably achieve the purpose of the service as required by federal law or regulation. When a rule is promulgated pursuant to this subsection (2), the state board shall provide a summary report of the limitations established by the rule and any fiscal impact of the rule to members of the health and human services committees of the senate and house of representatives, or any successor committees, and any other members of the general assembly who request the reports.

25.5-5-204. Presumptive eligibility - pregnant women - children - long-term care - state plan. (1) For purposes of this section, "presumptive eligibility" means the self-declaration of income, assets, and status in order to promptly receive medical assistance services prior to the verification of income, assets, and status.

(2) (a) A pregnant woman shall be presumptively eligible for the medical assistance program and shall receive services specified by federal law only if the woman declares all pertinent information relating to the criteria of income, assets, and status.

(b) A woman shall declare her immigration status unless the general assembly provides funding for prenatal care services for undocumented residents.

(2.5) A child under the age of eighteen years shall be presumptively eligible for the medical assistance program and shall receive services specified by federal law only if a parent or legal guardian of the child declares all pertinent information relating to the criteria of income, assets, and status of the child's family.

(2.7) (a) The state department is authorized to seek federal authorization to allow a person who is in need of long-term care, as defined in section 25.5-6-104, to be presumptively eligible for the medical assistance program pursuant to this article and articles 4 and 6 of this title.

(b) If the state department receives federal authorization pursuant to paragraph (a) of this subsection (2.7) and sufficient spending authority, a person in need of long-term care shall be presumptively eligible for the medical assistance program if the person or the person's legal representative declares all pertinent information relating to the criteria of income, assets, and immigration status. Such person shall be assessed for the appropriate level of care pursuant to section 25.5-6-104. If required due to limitations of federal authorization or spending authority, the state department may implement this paragraph (b) as a pilot program rather than statewide.

(c) The state department shall make any necessary changes to the state plan and waivers for home- and community-based service programs authorized pursuant to this article and articles 4 and 6 of this title to comply with this subsection (2.7).

(d) If it is determined that a recipient was not eligible for medical benefits after the recipient 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, and the county department shall not be responsible for any federal error rate sanctions resulting from such determination.

(3) The state department shall make any necessary changes to the state plan to comply with this section.

25.5-5-204.5. Continuous eligibility - children - repeal. (1) A child who is determined to be eligible for benefits under this article or under article 4 or 6 of this title shall remain eligible for twelve months subsequent to the last day of the month in which the child was enrolled; except that a child shall no longer be eligible and shall be disenrolled from the state medical assistance program if the state department becomes aware of or is notified that the child has moved out of the state or has reached nineteen years of age.

(2) Notwithstanding the provisions of subsection (1) of this section, if the moneys in the hospital provider fee cash fund established pursuant to section 25.5-4-402.3 (4), together with the corresponding federal matching funds, are insufficient to fully fund all of the purposes described in section 25.5-4-402.3 (4) (b), after receiving recommendations from the hospital provider fee oversight and advisory board established pursuant to section 25.5-4-402.3 (6), the state board by rule adopted pursuant to the provisions of section 25.5-4-402.3 (5) (b) (III) may eliminate the continuous enrollment requirement pursuant to this section.

(3) (a) Notwithstanding the provisions of subsection (1) of this section, continuous eligibility for children shall only be effective if the state department receives federal authorization for such eligibility.

(b) Within sixty days after the state department receives authorization to provide continuous eligibility for children, the executive director shall send written notice to the revisor of statutes informing him or her of the authorization.

(c) This subsection (3) is repealed, effective the July 1 following the receipt of the notice to the revisor of statutes.

25.5-5-205. Baby and kid care program - creation - eligibility. (1) The general assembly hereby finds and declares that the health and well-being of the children of Colorado are at risk; that access to prenatal care by pregnant women in Colorado is inadequate; that lack of access to prenatal care results in a high rate of low-weight births; that children born with low weight are more likely to develop health problems during their lifetimes; that providing such essential care during pregnancy and early childhood would reduce the number of children with such health problems; that providing such care would not only benefit such children but would also benefit the citizens of Colorado by

ensuring the present and future health of society and reducing the amount of state resources needed for such purposes; and that a significant need exists in Colorado for a program which utilizes medicaid funds to promote and provide such prenatal care and well child care.

(2) There is hereby created the baby and kid care program to promote and provide prenatal care and well child care to individuals who need such care but are currently unable to obtain it.

(3) (a) On and after April 1, 1990, children under the age of six years and pregnant women shall be eligible for benefits under the baby and kid care program; except that, for the purpose of eligibility under this subsection (3) only:

(I) Such individual's family income shall exceed the eligibility threshold used in determining eligibility for aid to families with dependent children assistance pursuant to rules in effect on July 16, 1996, and the method adopted by the state board pursuant to sections 25.5-5-101 (4) (c) and 25.5-5-201 (5) (c), but shall not exceed the equivalent of the percentage level of the federal poverty line that is specified pursuant to paragraph (b) of this subsection (3);

(II) (A) (Deleted by amendment, L. 2010, (HB 10-1043), ch. 92, p. 313, § 4, effective April 15, 2010.)

(B) No resource standard shall be applied to pregnant women as a condition of eligibility. Once initial eligibility has been established for a pregnant woman under this subsection (3), she shall be considered to be continuously eligible throughout the pregnancy and for the sixty days following the pregnancy, even if the woman's eligibility would otherwise terminate during such period due to an increase in income. A child born to a woman eligible for assistance pursuant to this subsection (3) shall be eligible for medical assistance until the child attains one year of age so long as the infant remains in the eligible woman's household and the woman would be eligible for assistance if she were pregnant.

(b) (I) For children under six years of age, the percentage level of the federal poverty line, as defined pursuant to 42 U.S.C. sec. 9902 (2), used to determine eligibility under this subsection (3) shall be one hundred thirty-three percent. If the federal government establishes a new federal minimum percentage level of the federal poverty line used to determine eligibility under this subsection (3) that is different from the level set in this subparagraph (I), the state department is authorized to meet such federal minimum level without requiring additional legislation; however, such minimum federal level shall be established by rule of the state board.

(II) For pregnant women, the percentage level of the federal poverty line, as defined pursuant to 42 U.S.C. sec. 9902 (2), used to determine eligibility under this subsection (3) shall be one hundred eighty-five percent. If the federal government establishes a new federal minimum percentage level of the federal poverty line used to determine eligibility under this subsection (3) that is different from the level set in this

subparagraph (II), the state department is authorized to meet such federal minimum level without requiring additional legislation; however, such minimum federal level shall be established by rule of the state board.

(c) (I) On and after September 1, 2011, children born after September 30, 1983, who have attained six years of age but have not attained nineteen years of age shall be eligible for benefits under the baby and kid care program. For the purpose of eligibility under this paragraph (c) only, such individual's family income shall exceed the eligibility threshold used in determining eligibility for aid to families with dependent children assistance pursuant to rules in effect on July 16, 1996, and the method adopted by the state board pursuant to sections 25.5-5-101 (4) (c) and 25.5-5-201 (5) (c), but shall not exceed the equivalent of the percentage level of the federal poverty line that is specified pursuant to subparagraph (II) of this paragraph (c).

(II) The percentage level of the federal poverty line, as defined pursuant to 42 U.S.C. sec. 9902 (2), used to determine eligibility under this paragraph (c) shall be equivalent to the family income eligibility threshold applied to children under six years of age pursuant to paragraph (b) of this subsection (3).

(d) An asset test shall not be applied as a condition of eligibility for a child under this subsection (3). A child under this subsection (3) whose family income does not exceed the applicable level pursuant to paragraph (b) or (c) of this subsection (3) shall be presumptively eligible under this section.

25.5-5-206. Medicaid buy-in program - disabled children - disabled adults - federal authorization - rules. (1) (a) Subject to available appropriations, the state department is authorized to seek federal authorization to and to establish a medicaid buy-in program or programs for:

(I) Disabled children; or

(II) Disabled adults who do not qualify for the medicaid buy-in program established pursuant to part 14 of article 6 of this title.

(b) The medicaid buy-in program or programs established pursuant to paragraph (a) of this subsection (1) may provide for premium and cost-sharing charges on a sliding fee scale based upon a family's income.

(2) The state board shall promulgate rules consistent with any federal authorization to implement and administer the medicaid buy-in program or programs established pursuant to paragraph (a) of subsection (1) of this section.

25.5-5-207. Adult dental benefit - adult dental fund - creation - legislative declaration. (1) (a) The general assembly hereby finds that:

(I) As of 2011, Colorado was one of only ten states that did not offer basic oral

health services to adults under medicaid;

(II) Research has shown that untreated oral health conditions negatively affect a person's overall health and that gum disease has been linked to diabetes, heart disease, strokes, kidney disease, Alzheimer's disease, and even mental illness;

(III) Regular dental care and prevention are the most cost-effective methods available to prevent minor oral conditions from developing into more complex oral and physical health conditions that would eventually require emergency and palliative care;

(IV) Further, one in four adults has untreated tooth decay. Early detection and access to preventive and restorative treatments for oral health conditions can be up to ten times less expensive than treating those same conditions in an emergency setting.

(V) Research has also shown that good oral health improves medicaid beneficiaries' ability to obtain and keep employment. Employed adults lose more than one hundred and sixty-four million hours of work each year due to dental problems.

(VI) Children are more likely to receive regular dental services if their parents have access to dental services; and

(VII) Pregnant women are one of the most vulnerable adult populations that are without oral health benefits under medicaid. During pregnancy, the physical changes a woman's body undergoes can negatively affect oral health. Untreated decay and periodontal disease are associated with adverse pregnancy outcomes such as increased risk for preeclampsia, pre-term labor, and low birth weight babies.

(b) Therefore, the general assembly declares that in order to improve overall health, promote savings in medicaid programs, and prevent future health conditions caused by oral health problems, it is in the best interest of the state of Colorado to create a limited oral health benefit for adults in the medicaid program.

(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 experience, service delivery models, and maximum efficiencies in the administration of the benefit.

(b) The state department shall determine the most cost-effective method for providing the adult dental benefit, including but not limited to a comparison of a capitated or fee-for-service method of payment and the purchase of dental insurance.

(c) The state department shall seek any federal authorization necessary to provide the adult dental benefit.

(3) If the state department chooses to use an administrative service organization to manage the adult dental benefit:

(a) The contract with the administrative service organization must provide that the contracting entity is prohibited from requiring dental providers to participate in any other public or private program or to accept any other insurance products as a condition of participating as a dental provider; and

(b) The state department shall retain policy-making authority, including but not limited to policies concerning covered benefits and rate setting.

(4) (a) There is hereby created in the state treasury the adult dental fund, referred to in this section as the "fund", consisting of moneys transferred to the fund from the unclaimed property trust fund pursuant to section 38-13-116.5 (2.8), C.R.S., and any moneys that may be appropriated to the fund by the general assembly. The moneys in the fund are subject to annual appropriation by the general assembly to the state department for the direct and indirect costs associated with implementing the adult dental benefit pursuant to section 25.5-5-202 (1) (w).

(b) The state treasurer may invest any unexpended moneys in the fund as provided by law. The state treasurer shall credit all interest and income derived from the investment and deposit of moneys in the fund to the fund.

(c) Any unexpended and unencumbered moneys remaining in the fund at the end of a fiscal year remain in the fund and shall not be credited or transferred to the general fund or another fund.

PART 3

SERVICES WITH SPECIAL STATE PROVISIONS

25.5-5-301. Clinic services. (1) As used in this article and articles 4 and 6 of this title, unless the context otherwise requires, "clinic services" means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to outpatients.

(2) Under the federal option for clinic services, Colorado has selected clinic services provided by the following:

- (a) Community mental health centers or clinics;
- (b) Community centered boards;
- (c) Birthing centers;
- (d) Ambulatory surgery facilities;
- (e) Freestanding dialysis clinics.

(3) "Clinic services" also means preventive, therapeutic, or palliative items or services that are furnished to patients by county or district public health agencies or county or district boards of health established pursuant to part 5 of article 1 of title 25, C.R.S., that are recommended for certification by the department of public health and environment as qualified to receive payments pursuant to this article and articles 4 and 6 of this title.

(4) "Clinic services" also means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that are furnished to a pregnant woman who is enrolled or eligible for services pursuant to section 25.5-5-101 (1) (c) or 25.5-5-205 in a facility that

is not a part of a hospital but is organized and operated as a freestanding alcohol or drug treatment program approved and licensed by the unit in the department of human services that administers behavioral health programs and services, including those related to mental health and substance abuse, pursuant to section 27-80-108 (1) (c), C.R.S.

(5) "Clinic services" also means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that are furnished to children up to age twenty-one or to high-risk pregnant women in a facility which is not a part of a hospital but is organized and operated as a school-based clinic.

(6) "Clinic services" also means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that are furnished to students by a school district, board of cooperative services, or state educational institution within the scope of the "Colorado Medical Assistance Act" pursuant to the provisions of section 25.5-5-318.

25.5-5-302. Clinic services - children and pregnant women - utilization of certain providers. (1) The state department shall utilize, to the extent possible and appropriate, county or district public health agencies or boards of health established pursuant to part 5 of article 1 of title 25, C.R.S., that are certified by the department of public health and environment as qualified to receive payments pursuant to this article and articles 4 and 6 of this title and that meet the requirements and standards set forth in rules promulgated by the state board in the state department pursuant to section 25.5-4-104 to provide clinic services to patients who are children under age seven or patients who are pregnant women.

(2) In complying with the provisions of subsection (1) of this section, the state department shall utilize, to the extent possible and appropriate, the county or district public health agencies and boards of health specified in subsection (1) of this section to provide outreach to eligible pregnant women and children and to provide clinic services:

(a) Upon the referral of any physician; or

(b) When there exists no primary care physician who agrees to provide clinic services to such patients.

25.5-5-303. Private-duty nursing. (1) The medical assistance program in this state shall include private-duty nursing to persons who are technology dependent and otherwise eligible as provided under this section.

(2) A recipient is eligible for private-duty nursing services if he or she:

(a) Is dependent on technology at least part of each day;

(b) Requires private-duty nursing care as determined in accordance with state department rules;

(c) Is able to be served safely under the limitations of the private-duty nursing

benefit and within the availability of services; and

(d) Is not residing in a nursing facility or hospital at the time of the delivery of the private-duty nursing services.

(3) (a) The state board shall establish rules in accordance with this section that identify medical criteria for determining the circumstances under which private-duty nursing services will be delivered to assure that only persons who need the services receive them and only to the extent medically necessary.

(b) Private-duty nursing services shall not be provided as twenty-four-hour care except in special circumstances and for limited time periods as established by the state department pursuant to this section.

(c) The home health agency, in conjunction with the family or in-home caregiver and the attending physician, shall include in a care plan that includes private-duty nursing services a process by which the eligible person may receive necessary care, which may include respite care, if the family or in-home caregiver is unavailable due to an emergency situation or to unforeseen circumstances. The family or in-home caregiver shall be duly informed by the home health agency of these alternative care provisions at the time the care plan is initiated.

(4) As used in this section, unless the context otherwise requires, "private-duty nursing" means nursing care that is more individualized and continuous than both the nursing care available under the home health benefit and the nursing care routinely provided in a hospital or nursing facility.

25.5-5-304. Hospice care. (1) The medical assistance program in this state shall include hospice care. Except as otherwise provided in subsection (2) of this section, hospice care shall be provided for a period of up to two hundred ten days in accordance with rules adopted by the state board, which rules shall comply with 42 U.S.C. sec. 1396d, and shall include at least the following requirements:

(a) That a person shall obtain a certified medical prognosis indicating a life expectancy of nine months or less, which certification shall comply with rules adopted by the state board;

(b) That a person shall execute a waiver of other medical benefits available under this article and articles 4 and 6 of this title, which election shall be executed in accordance with rules adopted by the state board;

(c) That the service shall be reasonable and necessary for the palliation or management of the terminal illness and related conditions.

(2) Hospice care may be provided to a person beyond two hundred ten days if such person is recertified by a physician or hospice medical director as terminally ill in accordance with subsection (1) of this section.

(3) (a) Subject to the receipt of any necessary federal authorization, for a person

who has executed the waiver described in paragraph (b) of subsection (1) of this section and who is a resident in a class I facility, as defined in section 25.5-6-201 (13), the class I facility shall bill the state department and the state department shall pay the class I facility for the room and board costs of the person.

(b) Subject to the receipt of any necessary federal authorization, the hospice care provided pursuant to this section may include room and board in a hospice inpatient facility licensed pursuant to section 25-3-101, C.R.S. The state department is authorized to establish the reimbursement rate for the costs for room and board at a licensed hospice inpatient facility for patients eligible for the routine level of hospice care.

(c) (I) If required, the state department shall seek the appropriate federal authorization, conditioned on the receipt of gifts, grants, or donations sufficient to provide for the state's administrative costs of preparing and submitting the request, to make the payment described in paragraph (a) of this subsection (3) and to include room and board at a licensed hospice inpatient facility as described in paragraph (b) of this subsection (3). On or before January 15, 2011, the state department shall submit a brief report to the members of the health and human services committees of the senate and house of representatives, or any successor committees, on the status of any request for authorization pursuant to this subparagraph (I). If federal authorization to implement the changes described in paragraphs (a) and (b) of this subsection (3) is obtained, the state department shall request, through the state budget process, that the changes be implemented during the fiscal year following the year in which the approval is obtained.

(II) The state department is authorized to seek and accept gifts, grants, or donations from private or public sources for the purpose of providing for the administrative costs of preparing and submitting the request for federal approval for the payments described in paragraphs (a) and (b) of this subsection (3). All such private and public funds received through gifts, grants, or donations shall be transmitted to the state treasurer, who shall credit the same to the hospice care account in the department of health care policy and financing cash fund created pursuant to section 25.5-1-109, which account is hereby created. Moneys in the account shall be subject to appropriation and shall only be used for the purposes described in this subparagraph (II).

(4) Repealed.

25.5-5-305. Pediatric hospice care - legislative declaration - federal authorization - rules - fund. (1) **Legislative declaration.** (a) The general assembly finds and declares that:

(I) The death of a child has a devastating and enduring impact on the child's family;

(II) Too often, children with fatal conditions and their families fail to receive compassionate and consistent care that meets their physical, emotional, and spiritual

needs;

(III) Better care is possible but current methods of organizing and financing palliative, end-of-life, and bereavement care impede the provision of services that are both more appropriate and more cost-efficient;

(IV) Current federal medicaid regulations contain inherent barriers to providing appropriate palliative and end-of-life care to pediatric patients. These barriers include requirements that preclude the pursuit of curative treatments, mandate a do-not-resuscitate order, and require physician certification that death is expected within six months.

(b) The general assembly declares that it is in the best interest of the state to investigate and implement hospice guidelines that provide appropriate, compassionate care to dying children and their families while proving to be cost-neutral or cost-saving to the state and federal medicaid programs.

(c) The general assembly further finds and declares that, while this direction immediately concerns federal approval for hospice care that recognizes the distinct circumstances of children facing life-threatening illnesses and their families, it is the intent of the general assembly that the information and data produced as a result of this act shall be used to improve the delivery of palliative and end-of-life services to persons of all ages when such improvements can be made in a manner that is cost-neutral or cost-saving to the state.

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

(a) "Eligible child" means a child who:

(I) Is less than nineteen years of age; and

(II) Is eligible for the state's medicaid program pursuant to section 25.5-5-101, 25.5-5-201, or 25.5-5-203;

(b) "Pediatric hospice care" means hospice care for eligible children as authorized in this section.

(3) **Pediatric hospice care.** (a) (I) The state department shall seek the appropriate federal authorization, conditioned on the receipt of gifts, grants, or donations sufficient to provide for the state's administrative costs of preparing and submitting the request, for pediatric hospice care that shall include but may not be limited to:

(A) Respite care;

(B) Expressive therapies, as defined in rule by the state board;

(C) Palliative care from the time of diagnosis of a potentially life-threatening illness; and

(D) A continuum of care through the coordination of services, which may include skilled, intermittent, and around-the-clock nursing care.

(II) The state department is authorized to seek federal approval for modifications to the provision of hospice care for adults who are eligible for the state's medicaid program.

(b) For the provision of pediatric hospice care, the state department shall seek an exemption from the following federal medicaid requirements for the eligibility of and election for hospice care:

(I) The mandatory do-not-resuscitate order;

(II) A physician's certification that a patient is expected to live less than six months; and

(III) The nonallowance of curative care therapies concurrent with palliative and hospice care.

(c) In any application for federal authorization pursuant to this section, the state department shall retain bereavement services to the extent available under federal law.

(d) Pediatric hospice care, as authorized pursuant to this section, shall meet aggregate federal waiver budget neutrality requirements.

(e) The state department shall implement the provision of pediatric hospice care to the extent authorized by the federal government.

(4) **Review.** The state department shall notify the joint budget committee of the general assembly of the extent to which the state department received federal authorization for pediatric hospice care services pursuant to this section in order for the joint budget committee to review the approved budget neutrality analysis for such services prior to the state department's implementation.

(5) **Rules.** The state department shall develop the service provisions for pediatric hospice care in consultation with medical professionals who have expertise in providing end-of-life and palliative care to pediatric patients and family members who have experienced the death of a child. The state board shall adopt rules necessary to implement and administer the provisions of this section.

(6) **Fund.** The state department is authorized to seek and accept gifts, grants, or donations from private or public sources for the purpose of providing for the administrative costs of preparing and submitting the request for federal approval for the provision of pediatric hospice care. All private and public funds received through gifts, grants, or donations shall be transmitted to the state treasurer, who shall credit the same to the pediatric hospice care cash fund, which fund is hereby created and referred to in this section as the "fund". The moneys in the fund shall be subject to annual appropriation by the general assembly for preparing and submitting the request for federal approval pursuant to this section. Any moneys in the fund not expended for the purpose of this section may be invested by the state treasurer as provided by law. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund. Any unexpended and unencumbered moneys remaining in the fund at the end of a fiscal year shall remain in the fund and shall not be credited or transferred or revert to the general fund or another fund.

25.5-5-306. Residential child health care - waiver - program - rules. (1) The state department, in cooperation with the department of human services, shall implement a program concerning residential child health care under this article and articles 4 and 6 of this title to provide services pursuant to article 67 of title 27, C.R.S., to medicaid-eligible children residing in residential child care facilities, as that term is defined in section 26-6-102 (8), C.R.S., to medicaid-eligible children residing in psychiatric residential treatment facilities, and children placed by the department of human services or through county departments of social services in licensed or certified out-of-home placement facilities. Children with developmental disabilities, as defined in section 27-10.5-102 (11), C.R.S., who are placed in such facilities shall meet the out-of-home placement criteria described in section 19-1-107, C.R.S., and shall be neglected or dependent as described in section 19-3-102, C.R.S. The state board shall establish the type of rehabilitative or medical assistance services to be provided under the program as described in subsection (3) of this section, to the extent such services are cost-efficient, and the recipient eligibility criteria that may include, but are not limited to, a medical necessity determination and a financial eligibility determination. The state board shall define in rule the staff permitted to order, monitor, and assess seclusion and restraint in psychiatric residential treatment facilities, and the corresponding restrictions on the use of seclusion and restraint.

Editor's note: This version of subsection (1) is effective until March 1, 2014.

(1) The state department, in cooperation with the department of human services, shall implement a program concerning residential child health care under this article and articles 4 and 6 of this title to provide services pursuant to article 67 of title 27, C.R.S., to medicaid-eligible children residing in residential child care facilities, as that term is defined in section 26-6-102 (8), C.R.S., to medicaid-eligible children residing in psychiatric residential treatment facilities, and children placed by the department of human services or through county departments of social services in licensed or certified out-of-home placement facilities. Children with intellectual and developmental disabilities, as defined in section 25.5-10-202, who are placed in such facilities shall meet the out-of-home placement criteria described in section 19-1-107, C.R.S., and shall be neglected or dependent as described in section 19-3-102, C.R.S. The state board shall establish the type of rehabilitative or medical assistance services to be provided under the program as described in subsection (3) of this section, to the extent such services are cost-efficient, and the recipient eligibility criteria that may include, but are not limited to, a medical necessity determination and a financial eligibility determination. The state board shall define in rule the staff permitted to order, monitor, and assess seclusion and restraint in psychiatric residential treatment facilities, and the corresponding restrictions on the use of seclusion and restraint.

Editor's note: This version of subsection (1) is effective March 1, 2014.

(2) The state department, in cooperation with the department of human services, may limit the number of recipients or providers participating in the program in accordance with any federal waiver obtained by the state department to implement this section.

(3) The state board, in cooperation with the department of human services, shall promulgate rules as necessary for the implementation of the program, including, but not limited to, rules regarding program services that may include rehabilitative services as appropriate to residential child health care when referred by a physician licensed pursuant to article 36 of title 12, C.R.S. a psychologist licensed pursuant to part 3 of article 43 of title 12, C.R.S., a registered professional nurse as defined in section 12-38-103 (11), C.R.S., who, by reason of postgraduate education and additional nursing preparation, has gained knowledge, judgment, and skill in psychiatric or mental health nursing, a clinical social worker licensed pursuant to part 4 of article 43 of title 12, C.R.S., a marriage and family therapist licensed pursuant to part 5 of article 43 of title 12, C.R.S., or a professional counselor licensed pursuant to part 6 of article 43 of title 12, C.R.S.; the number of recipients participating; eligibility criteria including financial eligibility criteria; reimbursement of providers; and such other rules as are necessary for the implementation and administration of the program. The county contribution established in section 26-1-122, C.R.S., for residential child care facilities may be used by the state to obtain federal financial participation under Title XIX of the social security act for any residential child health care program established pursuant to this section. The county contribution shall not be increased due to any federal financial participation received as a result of any programs established pursuant to this section. Nothing in this section shall be construed to prohibit an adjustment in the county contribution due to caseload or service cost increases. Nothing in this section shall be construed to create a county obligation to directly participate in the financing of any program established pursuant to the "Colorado Medical Assistance Act" as set forth in this article and articles 4 and 6 of this title.

(4) Services provided in a residential child care facility by a provisional licensee as defined in section 12-43-201 (7.8), C.R.S., to medicaid-eligible children shall receive medicaid reimbursement only if approved by the federal government.

25.5-5-307. Child mental health treatment and family support program. (1) The general assembly finds that many parents in Colorado who have experienced challenging circumstances because their children have significant mental health needs and who have attempted to care for their children or seek services on their behalf often are burdened with the excessive financial and personal costs of providing

such care. Private insurance companies may not cover mental health services and rarely cover residential mental health treatment services; those that do seldom cover a sufficient percentage of the expense to make such mental health treatment a viable option for many families in need. The result is that many families do not have the ability to obtain the mental health services that they feel their children desperately need. The general assembly finds that it is in the best interests of these families and the citizens of the state to encourage the preservation of family units by making mental health treatment available to these children pursuant to article 67 of title 27, C.R.S.

(2) In order to make mental health treatment available, it is the intent of the general assembly that each medicaid-eligible child who is diagnosed as a person with a mental illness, as that term is defined in section 27-65-102 (14), C.R.S., shall receive mental health treatment, which may include in-home family mental health treatment, other family preservation services, residential treatment, or any post-residential follow-up services, that shall be paid for through federal medicaid funding.

25.5-5-308. Breast and cervical cancer prevention and treatment program - creation - legislative declaration - definitions - funds - repeal. (1) The general assembly hereby finds and declares that breast and cervical cancer are significant health problems for women in this state. The general assembly further finds and declares that these cancers can and should be prevented and treated whenever possible. It is therefore the intent of the general assembly to enact this section to provide for the prevention and treatment of breast and cervical cancer to women where it is not otherwise available for reasons of cost.

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

(a) "Eligible person" means a person who:

(I) (A) Has been screened for breast or cervical cancer under the centers for disease control and prevention's national breast and cervical cancer early detection program established under Title XV of the federal "Public Health Service Act", 42 U.S.C. sec. 300k et seq., in accordance with the requirements of section 1504 of such act, 42 U.S.C. sec. 300n, on or after July 1, 2002, unless the centers for medicare and medicaid services approves the state department's amendment to the medical assistance plan and the state department is able to implement the breast and cervical cancer prevention and treatment program before such date, then the person must be screened on or after the implementation date of such program; or

(B) Has been screened for breast or cervical cancer by a provider who does not receive funds through the centers for disease control and prevention's national breast and cervical cancer early detection program but whose screening activities are recognized by the department of public health and environment as part of screening activities under the centers for disease control and prevention's national breast and cervical cancer early

detection program. This sub-subparagraph (B) shall apply only if the state department receives authority to receive federal financial participation for such persons. The state department shall request authority for federal financial participation when the state department determines that the amount of moneys accumulated in the eligibility expansion account created in paragraph (c) of subsection (8) of this section, including any amounts pledged or promised through a gift, grant, or donation, is sufficient to sustain the projected number of additional persons who would be eligible for the program under this sub-subparagraph (B).

(II) Has been diagnosed with breast or cervical cancer and is in need of breast or cervical cancer treatment;

(III) Has not yet attained sixty-five years of age; and

(IV) Does not have any creditable coverage as defined under federal law pursuant to 42 U.S.C. sec. 300gg (c).

(b) "Qualified entity" shall be defined pursuant to 42 U.S.C. sec. 1396r-1b(b)(2).

(3) There is hereby created a breast and cervical cancer prevention and treatment program to provide medical benefits to eligible persons under this section.

(4) (a) Benefits for medical assistance to an eligible person shall be made available beginning on the day on which a determination is made that the person is eligible for medical assistance and throughout the period in which such person meets the definition of an eligible person.

(b) Benefits for medical assistance to an eligible person shall also be available for the following period of presumptive eligibility:

(I) Such period of presumptive eligibility shall begin when a qualified entity determines that the eligible person is in need of treatment for breast or cervical cancer.

(II) Such period of presumptive eligibility shall end with the earlier of:

(A) The day on which a determination is made that the person is eligible or not eligible for medical assistance; or

(B) If the eligible person does not file a simplified application for medical assistance developed by the state department and approved by the centers for medicare and medicaid services on or before the last day of the month following the month during which the eligible person was found to be qualified for services under this section, then benefits shall end on such last day.

(5) The state department shall have the following powers and duties:

(a) To establish, operate, and monitor the breast and cervical cancer prevention and treatment program to provide medical assistance to eligible persons in accordance with the provisions of the federal "Breast and Cervical Cancer Prevention and Treatment Act of 2000", enacted October 24, 2000, Pub.L. 106-354, as amended;

(b) To amend the state's medical assistance plan to incorporate the breast and cervical cancer prevention and treatment program. The state department shall submit such proposed amendment to the centers for medicare and medicaid services regional office for

approval.

(c) To accept and expend any grant or award of moneys from the federal government, any moneys appropriated by the general assembly, any moneys received through gifts, grants, or donations from nonprofit or for-profit entities, and any interest and income earned on such moneys for the purposes set forth in this section;

(d) To inform the joint budget committee of the general assembly in writing as soon as practicable about any change in the rate of federal financial participation in the program.

(6) The state board shall adopt such rules as are necessary to carry out the provisions of this section.

(7) The breast and cervical cancer prevention and treatment program shall be subject to the annual financial and compliance audit of the "Colorado Medical Assistance Act" performed by the state auditor's office and shall not be considered a tobacco settlement program for purposes of section 2-3-113, C.R.S., or section 25-1-108.5, C.R.S.

(8) (a) (I) There is hereby created in the state treasury the breast and cervical cancer prevention and treatment fund, referred to in this subsection (8) as the "fund". The fund shall consist of any moneys credited thereto pursuant to section 24-22-115 (1), C.R.S., any gifts, grants, and donations, any moneys appropriated thereto by the general assembly, and any moneys transferred from the eligibility expansion account pursuant to subparagraph (III) of paragraph (c) of this subsection (8). Except as provided for in paragraph (b.5) of this subsection (8), all moneys credited to the fund and all interest and income earned on the moneys in the fund shall remain in the fund for the purposes set forth in this section. Any unexpended and unencumbered moneys remaining in the fund at the end of a fiscal year shall remain in the fund and shall not be credited or transferred to the general fund or another fund. The state department is encouraged to secure private gifts, grants, and donations to fund the state costs of the breast and cervical cancer prevention and treatment program.

(II) Moneys in the fund may be used to cover the administrative costs of the department of public health and environment to recognize providers in accordance with sub-subparagraph (B) of subparagraph (I) of paragraph (a) of subsection (2) of this section as providing screening activities under the centers for disease control and prevention's national breast and cervical cancer early detection program.

(b) Repealed.

(b.5) Until section 24-30-2204.5, C.R.S., is repealed, the state treasurer shall transfer any interest or income earned on moneys in the fund to the disability investigational and pilot support fund, created in section 24-30-2205.5, C.R.S.

(c) (I) There is hereby created, as an account within the fund, the eligibility expansion account, referred to in this subsection (8) as the "account". The account shall consist of moneys credited thereto pursuant to section 42-3-217.5 (3) (c), C.R.S., any gifts, grants, and donations, and any other moneys appropriated thereto by the general

assembly. Moneys in the account shall be expended only to fund the cost to expand the eligibility criteria for participation in the breast and cervical cancer prevention and treatment program to persons described in sub-subparagraph (B) of subparagraph (I) of paragraph (a) of subsection (2) of this section who are screened for breast or cervical cancer by a provider who does not receive funds through the centers for disease control and prevention's national breast and cervical cancer early detection program established under Title XV of the federal "Public Health Service Act", 42 U.S.C. sec. 300k et seq., to provide screening activities. The state department shall not be required to track or report on the persons who become eligible for participation in the breast and cervical cancer prevention and treatment program pursuant to sub-subparagraph (B) of subparagraph (I) of paragraph (a) of subsection (2) of this section separately from those persons who are eligible for the program pursuant to sub-subparagraph (A) of subparagraph (I) of paragraph (a) of subsection (2) of this section, nor shall the state department be required to track or report separately on expenditures related to persons eligible to participate in the program pursuant to either such sub-subparagraph.

(II) Notwithstanding paragraph (b.5) of this subsection (8), all moneys credited to the account and all interest and income earned on the moneys in the account shall remain in the account for the purposes set forth in this paragraph (c) and shall not be credited or transferred to the general fund or any other fund except as provided in subparagraph (III) of this paragraph (c). The state department is encouraged to secure private gifts, grants, and donations to help fund the costs to expand the eligibility criteria for participation in the breast and cervical cancer prevention and treatment program as described in this paragraph (c).

(III) (A) Upon determining that the amount of moneys accumulated in the account, including any amounts pledged or promised through a gift, grant, or donation, is sufficient to sustain the projected number of additional persons who would be eligible for the program under sub-subparagraph (B) of subparagraph (I) of paragraph (a) of subsection (2) of this section, and upon obtaining authority to receive federal financial participation for persons eligible under sub-subparagraph (B) of subparagraph (I) of paragraph (a) of subsection (2) of this section, the state department shall notify the joint budget committee that the account balance is sufficient to expand eligibility for the program and shall request an appropriation for the fiscal year for which the federal authority has been granted to fund the persons eligible pursuant to sub-subparagraph (B) of subparagraph (I) of paragraph (a) of subsection (2) of this section.

(B) Once the state department has notified the joint budget committee, the staff director of the joint budget committee shall request that the state treasurer transfer the moneys in the eligibility expansion account to the breast and cervical cancer prevention and treatment fund and dissolve the account.

(C) This paragraph (c) is repealed, effective when the state treasurer transfers the balance of the eligibility expansion account to the breast and cervical cancer prevention

and treatment fund and dissolves the account. The state treasurer shall notify the revisor of statutes in writing when the conditions specified in this sub-subparagraph (C) have been satisfied.

(9) (a) For the fiscal year 2005-06, the general assembly shall appropriate fifty percent of the state costs of the breast and cervical cancer prevention and treatment program from the general fund and fifty percent from the moneys credited to the breast and cervical cancer prevention and treatment fund pursuant to section 24-22-115 (1), C.R.S., to such program.

(b) For the fiscal year 2006-07, the general assembly shall appropriate seventy-five percent of the state costs of the breast and cervical cancer prevention and treatment program from the general fund and twenty-five percent from the moneys credited to the breast and cervical cancer prevention and treatment fund pursuant to section 24-22-115 (1), C.R.S., to such program.

(c) For the fiscal year 2007-08, the general assembly shall appropriate one hundred percent of the state costs of the breast and cervical cancer prevention and treatment program from the moneys credited to the breast and cervical cancer prevention and treatment fund pursuant to section 24-22-115 (1), C.R.S., to such program.

(d) For the fiscal year 2008-09, the general assembly shall appropriate one hundred percent of the state costs of the breast and cervical cancer prevention and treatment program from the moneys credited to the breast and cervical cancer prevention and treatment fund pursuant to section 24-22-115 (1), C.R.S., to such program.

(e) For the fiscal years 2009-10 through 2011-12, the general assembly shall annually appropriate one hundred percent of the state costs of the breast and cervical cancer prevention and treatment program from the moneys credited to the breast and cervical cancer prevention and treatment fund pursuant to section 24-22-115 (1), C.R.S., to such program.

(f) For the fiscal years 2012-13 and 2013-14, the general assembly shall annually appropriate fifty percent of the state costs of the breast and cervical cancer prevention and treatment program from the general fund and fifty percent from the moneys credited to the breast and cervical cancer prevention and treatment fund pursuant to section 24-22-115 (1), C.R.S., to such program.

(10) This section is repealed, effective July 1, 2014, unless, in any fiscal year before such date, moneys received as federal financial participation provided pursuant to the federal "Breast and Cervical Cancer Prevention and Treatment Act of 2000", enacted October 24, 2000, Pub.L. 106-354, as amended, are no longer available to the fund or the rate of federal financial participation has been decreased, in which case the general assembly may repeal this section at the regular session of the general assembly immediately following such decrease or discontinuation of federal moneys.

25.5-5-309. Pregnant women - needs assessment - referral to treatment program. (1) The health care practitioner for each pregnant woman who is enrolled or eligible for services pursuant to section 25.5-5-101 (1) (c) or 25.5-5-205 shall be encouraged to identify as soon as possible after such woman is determined to be pregnant whether such woman is at risk of a poor birth outcome due to substance abuse during the prenatal period and in need of special assistance in order to reduce such risk. If the health care practitioner makes such a determination regarding any pregnant woman, the health care practitioner shall be encouraged to refer such woman to any entity approved and licensed by the department of human services for the performance of a needs assessment. Any pregnant woman who is eligible for services pursuant to section 25.5-5-205 may refer herself for such needs assessment.

(2) For the purposes of this section, unless the context otherwise requires, a "needs assessment" means an assessment that is designed to make a determination of what services are needed by a pregnant woman to minimize the occurrence of a poor birth outcome due to substance abuse by such pregnant woman.

25.5-5-310. Treatment program for high-risk pregnant women - cooperation with private entities. The state department and the departments of human services and public health and environment shall cooperate with any private entities that desire to assist such departments in the provision of services connected with the treatment program for high-risk pregnant women. Private entities may provide services that are not provided to persons pursuant to this article or article 4 or 6 of this title or article 2 of title 26, C.R.S., which may include, but shall not be limited to, needs assessment services, preventive services, rehabilitative services, care coordination, nutrition assessment, psychosocial counseling, intensive health education, home visits, transportation, development of provider training, child care, and other necessary components of residential or outpatient treatment or care.

25.5-5-311. Treatment program for high-risk pregnant women - data collection. The state department, in cooperation with the department of human services, shall create a data collection mechanism regarding persons receiving services pursuant to the treatment program for high-risk pregnant women which shall include the collection of such data as such departments deem appropriate.

25.5-5-312. Treatment program for high-risk pregnant women - extended coverage - federal approval. The state department shall seek federal approval to continue providing substance abuse treatment services for twelve months following a

pregnancy to women who are eligible to receive services under the medical assistance program, who are receiving services pursuant to the treatment program for high-risk pregnant women, and who continue to participate in the treatment program. The state department shall implement the continued services to the extent allowed by the federal government.

25.5-5-313. Outpatient substance abuse treatment - report of state auditor - amendment to state plan - repeal. (Repealed)

25.5-5-314. Substance abuse treatment for native Americans - federal approval - repeal. (1) The state department shall request federal approval, conditioned on the receipt of gifts, grants, or donations sufficient to provide for the state's administrative costs of preparing and submitting the request, to include any substance abuse treatment benefits available to native Americans in which there is one hundred percent federal financial participation.

(2) (a) If sufficient moneys to support the cost of preparing a request for federal approval have not been credited to the native American substance abuse treatment cash fund established in section 25.5-5-315 prior to December 31, 2004, the state treasurer shall immediately provide notification of such fact to the state department and to the revisor of statutes.

(b) This section is repealed upon receipt by the revisor of statutes of the notification described in paragraph (a) of this subsection (2).

25.5-5-315. Acceptance of gifts, grants, and donations - native American substance abuse treatment cash fund - repeal. (1) The executive director may accept and expend moneys from gifts, grants, and donations for purposes of providing for the administrative costs of preparing and submitting the request for federal approval to provide substance abuse treatment services to native Americans as provided for in section 25.5-5-314. All such gifts, grants, and donations shall be transmitted to the state treasurer who shall credit the same to the native American substance abuse treatment cash fund, which fund is hereby created. The moneys in the native American substance abuse treatment cash fund shall be subject to annual appropriation by the general assembly. All investment earnings derived from the deposit and investment of moneys in the native American substance abuse treatment cash fund shall remain in the fund and shall not be transferred or revert to the general fund of the state at the end of any fiscal year.

(2) (a) If sufficient moneys have not been credited to the native American substance abuse treatment cash fund for the purpose of preparing the request for federal

approval required under section 25.5-5-314 prior to December 31, 2004, the state treasurer shall immediately provide notification of such fact to the state department and to the revisor of statutes.

(b) This section is repealed upon receipt by the revisor of statutes of the notification described in paragraph (a) of this subsection (2).

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. 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 with a particular disease or combination of diseases. The disease management programs shall target medicaid recipients 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 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).

(3) If the state department implements any disease management programs authorized in subsection (2) of this section, the state department shall report to the joint budget committee of the general assembly an estimate of the fiscal implications generated by the implementation of the disease management programs. Such report shall be made on or before February 1 of the year following the implementation of a disease management program and on or before each February 1 thereafter in which such program is in place.

25.5-5-317. Obesity treatment pilot program - development and implementation - report - repeal. (Repealed)

25.5-5-318. Health services - provision by school districts - repeal. (1) As used in this section:

(a) "School district" means any board of cooperative services established pursuant to article 5 of title 22, C.R.S., any state educational institution that serves students in kindergarten through twelfth grade including, but not limited to, the Colorado school for the deaf and the blind, created in article 80 of title 22, C.R.S., and any public school district organized under the laws of Colorado, except a junior college district.

(b) "Underinsured" means a person who has some health insurance, but whose insurance does not adequately cover the types of health services for which a school district may receive federal matching funds under this section.

(2) (a) Any school district may contract with the state department under this section to receive federal matching funds for amounts spent in providing health services through the public schools to students who are receiving medicaid benefits pursuant to this article and articles 4 and 6 of this title.

(a.5) Repealed.

(b) Approval of contracts under this section does not constitute a commitment by the general assembly to continue providing health services to students through the public schools using state general funds if federal matching funds are not available in the future. Any moneys provided to a school district pursuant to a contract entered into under this section shall not supplant state or local moneys provided to school districts pursuant to the provisions of articles 20 to 28 or article 54 of title 22, C.R.S.

(c) Nothing in this section shall be construed as requiring any school district to enter into a contract as provided in this section. Participation in a contract by a school district is voluntary.

(d) The state department may make contracting and reimbursement of moneys under this section contingent upon either:

(I) The contracting school district certifying to the state department, through the department of education, that it has expended local and state moneys in an amount sufficient to meet the nonfederal share of expenditures being claimed for federal financial participation; or

(II) The contracting school district meeting the requirements of the intergovernmental transfer provisions of the federal medicaid law, 42 U.S.C. sec. 1396 et seq.

(3) Each year, by a date established by rule of the state board, the department of education shall notify the state department concerning any school district that chooses to

enter into a contract as provided in this section and the anticipated level of funding for the school district. Nothing in this section shall be construed to require a school district to maintain the same level of funding or services from year to year.

(4) (a) (I) Each school district that chooses to enter into a contract as provided in this section shall develop a services plan with input from the local community that identifies the types of health services needed by students within the school district and the services it anticipates providing. Except for medical emergencies and services related to allegations of child abuse, a student's participation in any psychological, behavioral, social, or emotional services, including counseling or referrals, shall be optional and shall require the prior written and informed consent of a parent or legal guardian of the student.

(II) (A) Any health questionnaire or form related to services funded in part through this section shall only relate to the student's personal health, habits, or conduct and shall not include questions concerning the habits or conduct of any other member of the student's family.

(B) No medical or health data or information identifying the student or the student's family shall be disclosed to any person other than a person specifically authorized to receive the information or data without the prior written and informed consent of a parent or legal guardian of the student.

(b) Each school district that chooses to enter into a contract as provided in this section shall perform an assessment of the health care needs of its uninsured and underinsured students and may spend an appropriate portion, not to exceed thirty percent, of the federal moneys received on health care for low-income students. For purposes of this paragraph (b), "low-income students" means students whose families are below one hundred eighty-five percent of the federal poverty line.

(c) The school district shall submit the services plan to the department of education with a notice of participation for purposes of technical assistance evaluation and to the executive director for approval.

(5) Each year not less than ninety days prior to the notification date established pursuant to subsection (3) of this section, the state department shall provide information through the department of education to school districts regarding the amount of available moneys and the administrative activities required to enter into a contract for federal matching funds for that year. To the extent allowed by existing resources, the department of education shall provide technical assistance to school districts in determining levels of funding, meeting administrative requirements, and developing services plans.

(6) Following the notification date established pursuant to subsection (3) of this section, each contracting school district, through the department of education, shall enter into a contract with the state department specifying the health services to be provided by the school district, the amount to be expended in providing the services, and the amount of federal matching funds for which the school district is eligible under the contract.

(7) The state department is authorized to accept and expend donations,

contributions, grants, including federal matching funds, and other moneys that it may receive to finance the costs associated with implementing this section.

(8) (a) Under the contract entered into pursuant to this section, a contracting school district shall receive from the state department all of the federal matching funds for which it is eligible under the contract, less the amount of state administrative costs allowed under paragraph (b) of this subsection (8). All moneys received by a school district pursuant to this section shall be used only to offset costs incurred for provision of student health services by the school district or to cash fund student health services in the school district.

(b) Total allowable state administrative costs for contracts entered into under this section for both the state department and the department of education shall not exceed ten percent of the total annual amount of federal funds reflected by the general assembly for such contracts in the annual general appropriations bill. State administrative costs include costs incurred in evaluating the implementation of this section.

(9) The state board shall specify by rule the types of health services for which a school district may receive federal matching funds under a contract created under this section, including but not limited to:

- (a) Basic primary, physical, dental, and mental health services;
- (b) Rehabilitation services;
- (c) Early and periodic screening, diagnosis, and treatment services; and
- (d) Service coordination, outreach, enrollment, and administrative support.

(10) (a) A school district that provides health services under contract pursuant to this section may provide the health services directly or through contractual relationships or agreements with public or private entities, as allowed by applicable federal regulations. However, no moneys shall be expended in any form for abortions, except as provided in section 25.5-4-415 or as required by federal law.

(b) Where possible, the school district shall coordinate the provision of health services to a student with the student's primary health care provider. Except for those services that are required by an individualized educational program developed pursuant to section 22-20-108 (4), C.R.S., or by a section 504 plan developed pursuant to the federal "Rehabilitation Act of 1973", 29 U.S.C. sec. 701 et seq., school districts shall not claim reimbursement under this section for direct services to students enrolled in health maintenance organizations that would normally be provided to students by their health maintenance organization.

(11) (a) The executive director shall apply for and secure any federal waivers and state plan amendments required to implement this section.

(b) This section shall remain in effect only for so long as federal financial participation is available for reimbursements to school districts. In the event, as specified in writing by the attorney general to the governor that federal law does not allow or is amended to disallow reimbursements to school districts or otherwise prevent the

implementation of this section, this section is repealed, effective on the date of the attorney general's opinion.

(12) The state department and the department of education shall work with the office of state planning and budgeting and the joint budget committee in implementing this section.

(13) The state department and the department of education shall enter into an interagency agreement to provide for the implementation of this section. The state board and the state board of education are authorized to promulgate rules as may be necessary in accordance with the agreement.

(14) The state department shall annually, or more often as necessary, hold a public hearing to receive comments from school districts, state agencies, and interested persons regarding implementation of this section.

(15) On or before December 15, 2002, the state department shall submit a formal evaluation of the implementation of this section to the committees on education and the committees on health and human services of the house of representatives and the senate, or any successor committees.

25.5-5-319. Family planning pilot program - rules - federal waiver - repeal. (1) There is hereby established a family planning pilot program for the provision of family planning services to categorically eligible individuals who are at or below a percentage of the federal poverty line established pursuant to the federal waiver sought pursuant to subsection (2) of this section. The state board shall promulgate rules setting forth the family planning services to be provided under the family planning pilot program.

(2) The executive director of the state department, in consultation with the department of public health and environment, shall seek a federal waiver that is cost-neutral to the state general fund for the implementation of the family planning pilot program established pursuant to this section such that ten percent of the family planning services provided to low-income families pursuant to the program as described in subsection (1) of this section would be funded with state general fund moneys and ninety percent would be funded with federal matching funds. In the federal waiver, the executive director shall not seek authority to waive or disregard the provisions of 42 U.S.C. sec. 1396a (a) (23) (B).

(3) (a) Upon issuance of the federal waiver sought pursuant to subsection (2) of this section, the departments of health care policy and financing and public health and environment shall seek the necessary appropriation of general funds through the normal budgetary process for the implementation of this act.

(b) The executive director of the state department is authorized to accept and expend on behalf of the state any funds, grants, gifts, and donations from any private or public source for the purpose of implementing the family planning pilot program

established in this section; except that no gift, grant, donation, or funds shall be accepted if the conditions attached thereto require the expenditure thereof in a manner contrary to law.

(4) The executive director of the state department, or such executive director's designee, shall prepare a written report for the members of the general assembly concerning the findings of the department based upon the family planning pilot program. Such report shall be provided to the members of the general assembly not more than three years after commencement of the program. The report shall address the number of individuals served, the type of services provided, the cost of the program, and such other information as the executive director deems appropriate.

(5) The implementation of this section is conditioned upon the issuance of any necessary waiver by the federal government and available appropriations pursuant to paragraph (a) of subsection (3) of this section. The provisions of this section shall be implemented to the extent authorized by federal waiver. The pilot program established by this section shall continue for five years from the receipt of the federal waiver or for so long as specified in the federal waiver. The executive director of the state department shall provide written notice to the revisor of statutes of the final termination date of the waiver, and this section shall be repealed, effective July 1 five years after the issuance of the federal waiver or July 1 in the year in which the waiver is terminated, whichever occurs first.

25.5-5-320. Telemedicine - reimbursement - disclosure statement. (1) On or after July 1, 2006, in-person contact between a health care or mental health care provider and a patient shall not be required under the state's medical assistance program for health care or mental health care services delivered through telemedicine that are otherwise eligible for reimbursement under the program. The services shall be subject to reimbursement policies developed pursuant to the medical assistance program. This section also applies to managed care organizations that contract with the state department pursuant to the statewide managed care system only to the extent that:

(a) Health care or mental health care services delivered through telemedicine are covered by and reimbursed under the medicaid per diem payment program; and

(b) Managed care contracts with managed care organizations are amended to add coverage of health care or mental health care services delivered through telemedicine and any appropriate per diem rate adjustments are incorporated.

(2) The reimbursement rate for a telemedicine service shall, as a minimum, be set at the same rate as the medical assistance program rate for a comparable in-person service. The state department may consider setting the reimbursement rate on a monthly basis as well as on a daily or per-visit basis.

(3) The state department shall establish rates for transmission cost reimbursement

for telemedicine services, considering, to the extent applicable, reductions in travel costs by health care or mental health care providers and patients to deliver or to access such services and such other factors as the state department deems relevant.

(4) A health care or mental health care provider who delivers health care or mental health care services through telemedicine shall provide to each patient, before treating that patient through telemedicine for the first time, the following written statements:

(a) That the patient retains the option to refuse the delivery of the services via telemedicine at any time without affecting the patient's right to future care or treatment and without risking the loss or withdrawal of any program benefits to which the patient would otherwise be entitled;

(b) That all applicable confidentiality protections shall apply to the services; and

(c) That the patient shall have access to all medical information resulting from the telemedicine services as provided by applicable law for patient access to his or her medical records.

(5) Subsection (4) of this section shall not apply in an emergency.

25.5-5-321. Telemedicine - home health care - home health telemedicine cash fund - rules. (1) On or after August 11, 2010, at-home telemedicine shall be eligible for reimbursement under the state's medical assistance program. The services delivered through telemedicine shall be subject to reimbursement policies promulgated by rule of the state board after consultation with home health care and home- and community-based services providers. This section also applies to managed care organizations that contract with the state department pursuant to the statewide managed care system, but only to the extent that:

(a) Home health care or home- and community-based services delivered through telemedicine are covered by and reimbursed under the medicaid program; and

(b) Managed care contracts with managed care organizations are amended to add coverage of home health care or home- and community-based services delivered through telemedicine.

(2) (a) The reimbursement rate for home health care or home- and community-based services delivered through telemedicine that are otherwise eligible for reimbursement under the medical assistance program shall be set by rule of the state board and shall be:

(I) In the form of a flat fee in one or more levels, depending on acuity.

(II) (Deleted by amendment, L. 2010, (HB 10-1005), ch. 345, p. 1598, § 1, effective August 11, 2010.)

(b) Any cost savings identified pursuant to this section shall be considered for use in paying for home- and community-based services under part 6 of this article,

community-based long-term care, and home health services.

(c) For the first two years after August 11, 2010, gifts, grants, and donations shall be used to implement this section. Gifts, grants, and donations made for this purpose shall be transferred to the home health telemedicine cash fund, which is hereby created in the state treasury. Moneys in the home health telemedicine cash fund shall be appropriated to the state board and used to implement this section. Moneys in the fund shall remain in the fund and not be transferred to the general fund at the end of any fiscal year. After two years or if the moneys in the cash fund are depleted, the department is authorized to go through the normal budget process to continue implementation of this section.

(3) Reimbursement shall not be provided for purchase or lease of telemedicine equipment.

(4) (a) A home health care or home- and community-based services provider who delivers services through telemedicine shall provide to each patient, before treating that patient through telemedicine for the first time, the following written statements:

(I) That the patient retains the option to refuse the delivery of home health care or home- and community-based services via telemedicine at any time without affecting the patient's right to future care or treatment and without risking the loss or withdrawal of any program benefits to which the patient would otherwise be entitled;

(II) That all applicable confidentiality protections shall apply to the services; and

(III) That the patient shall have access to all medical information resulting from the telemedicine services as provided by applicable law for patient access to his or her medical records.

(b) The provisions of paragraph (a) of this subsection (4) shall not apply in an emergency.

(5) Nothing in this section shall be construed to:

(a) Alter the scope of practice of any home health care or home- and community-based services provider; or

(b) Authorize the delivery of home health care or home- and community-based services in a setting or manner not otherwise authorized by law.

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), the state board shall adopt by rule a system to allow pharmacies to be reimbursed for providing certain over-the-counter medications to recipients 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 be identified through the drug utilization review process established in section 25.5-5-506, and shall be limited to medications that, if reimbursed, shall result in overall cost savings to the state.

(b) After the list of over-the-counter medications is identified pursuant to paragraph (a) of this subsection (1), the state department shall request, through the state budget process, that the reimbursements be implemented. The state department shall report to the joint budget committee annually concerning the amount of any savings realized from the reimbursements.

(2) (a) The state board, in consultation with the state board of pharmacy created pursuant to section 12-42.5-103, C.R.S., shall establish by rule standards for when a licensed pharmacist may prescribe over-the-counter medications as provided under this section for purposes of receiving reimbursement under the medical assistance program.

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

PART 4

STATEWIDE MANAGED CARE SYSTEM

25.5-5-401. Short title. This part 4 shall be known and may be cited as the "Statewide Managed Care System".

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

(2) The managed care system implemented pursuant to this article shall not include:

(a) The services delivered under the residential child health care program described in section 25.5-5-306, except in those counties in which there is a written agreement between the county department of social services, the designated and contracted behavioral health organization selected pursuant to section 25.5-5-411, and the state department;

(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 who have been determined to be in need of such services pursuant to the "Colorado Medical Assistance Act" and the state board's rules.

(3) **Bidding.** The state department is authorized to institute a program for

competitive bidding pursuant to section 24-103-202 or 24-103-203, C.R.S., for managed care entities seeking to provide medical services for medicaid clients eligible to be enrolled in managed care. The state department is authorized to award contracts to more than one offeror. The state department procedures shall seek to use competitive bidding procedures to maximize the number of managed care choices available to medicaid clients over the long term that meet the requirements of sections 25.5-5-404 and 25.5-5-406.

(4) **Waivers.** The implementation of this part 4 is conditioned, to the extent applicable, on the issuance of necessary waivers by the federal government. The provisions of this part 4 shall be implemented to the extent authorized by federal waiver, if so required by federal law.

(5) **Graduate medical education.** The state department shall continue the graduate medical education, referred to in this subsection (5) 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 enrolled in an MCE shall be excluded from the premiums paid to the MCE and shall be paid directly to the teaching hospital. The state board shall adopt rules to implement this subsection (5) and establish the rate and method of reimbursement.

(6) (a) For requests for proposals occurring on and after January 1, 2015, the state department shall allow for payment proposals that include, but need not be limited to, global payment, risk adjustment, risk sharing, and aligned payment incentives, including, but not limited to, gainsharing, for health benefits and services provided to medical assistance clients pursuant to sections 25.5-5-404 (1) (k) and (1) (l), 25.5-5-406 (2), and paragraph (b) of subsection (2) of this section.

(b) The state department shall have the discretion to determine which proposals satisfy the request for proposal, including:

(I) Whether the proposals are appropriate for the state's coordinated care system; and

(II) The state department's ability to ensure inpatient and outpatient hospital reimbursements are maximized up to the upper limits, as defined in 42 CFR 447.272 and 42 CFR 447.321 and calculated by the state department periodically.

(c) The state department may seek any federal waiver necessary to ensure that the effect of the request for proposals does not adversely impact upper payment limits and considerations shall include, but are not limited to, the establishment of an uncompensated care cost pool or a hospital incentive program.

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

(1) "Behavioral health organization", referred to in this part 4 as a "BHO", means an entity contracting with the state department to provide only behavioral health services.

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

(a) Has historically served medically needy or medically indigent patients and that demonstrates a commitment to serve low-income and medically indigent populations who comprise a significant portion of its patient population or, in the case of a sole community provider, serves the medically indigent patients within its medical capability; and

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

(2.5) "Global payment" means a population-based payment mechanism that is constructed on a per-member, per-month calculation. Global payments shall account for prospective local community or health system cost trends and value, as measured by quality and satisfaction metrics, and shall incorporate community cost experience and reported encounter data to the greatest extent possible to address regional variation and improve longitudinal performance. Risk adjustments, risk-sharing, and aligned payment incentives may be utilized to achieve performance improvement. The rate calculations for global payment are exempt from the provisions of section 25.5-5-408. An entity that uses global payment pursuant to section 25.5-5-404 shall meet the applicable financial solvency requirements of section 25.5-5-404 (1) (k) and (1) (l), and the essential community provider requirements of section 25.5-5-404 (2) and (3).

(3) (a) "Managed care" means:

(I) A predefined set of services to recipients delivered by a managed care entity as defined in subsection (4) of this section; or

(II) The delivery of services provided by the primary care physician program established in section 25.5-5-407, which is a primary care case manager as defined in subsection (8) of this section.

(III) (Deleted by amendment, L. 2008, p. 390, § 2, effective August 5, 2008.)

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

(4) "Managed care entity", referred to in this part 4 as an "MCE", means an entity that enters into a contract to provide services in a managed care system, including managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans but excluding primary care case managers, as defined in subsection (8) of this section.

(5) "Managed care organization", referred to in this part 4 as an "MCO", means an entity contracting with the state department that meets the definition of managed care organization as defined in 42 CFR 438.2.

(6) "Prepaid ambulatory health plan", referred to in this part 4 as a "PAHP", means an entity contracting with the state department that meets the definition of prepaid

ambulatory health plan as defined in 42 CFR 438.2.

(7) "Prepaid inpatient health plan", referred to in this part 4 as "PIHP", means an entity contracting with the state department that meets the definition of prepaid inpatient health plan as defined in 42 CFR 438.2.

(8) "Primary care case manager", referred to in this part 4 as a "PCCM", means an entity contracting with the state department that meets the definition of primary care case manager as defined in 42 CFR 438.2.

25.5-5-404. Selection of managed care entities. (1) In addition to any other criteria specified in rule by the state board, in order to participate in the managed care system, the MCE shall comply with specific criteria that include, but are not limited to, the following:

(a) The MCE shall not interfere with appropriate medical care decisions rendered by the provider nor penalize the provider for requesting medical services outside the standard treatment protocols developed by the MCE or its contractors.

(b) The MCE shall make or ensure payments to providers within the time allowed for the state to make payments on state liabilities under the rules adopted by the department of personnel pursuant to section 24-30-202 (13), C.R.S.

(c) The MCE shall have an educational component in its plan that takes into consideration recipient input and that informs recipients as to availability and use of the medical services system, appropriate preventive health care procedures, self-care, and appropriate health care utilization.

(d) The MCE shall provide the minimum benefit requirements as established by the state board.

(e) The MCE shall provide necessary and appropriate services to recipients that shall include but not be limited to the following:

(I) With respect to recipients who are unable to make decisions for themselves, the MCE and all relevant providers in the MCE's network serving the recipients shall collaborate with the designated advocate or family member in all decision-making, including enrollment and disenrollment.

(II) The MCE shall deliver services that are covered benefits in a manner that accommodates or is compatible with the recipient's ability to fulfill duties and responsibilities in work and community activities.

(f) The MCE shall provide appropriate use of ancillary health care providers by appropriate qualified health care professionals.

(g) The MCE shall comply with all data collection and reporting requirements established by the state department.

(h) The MCE shall, to the extent provided by law or waiver, provide recipient benefits that the state board shall develop and the state department shall implement in

partnership with local government and the private sector, including but not limited to:

- (I) Recipient options to rent, purchase, or own durable medical equipment; or
- (II) (Deleted by amendment, L. 2008, p. 392, § 3, effective August 5, 2008.)
- (III) Receipt of medical disposable supplies without charge.

(i) The MCE shall comply with utilization requirements established by the state department.

(j) The MCE shall develop and utilize a form or process for measuring group and individual recipient health outcomes, including but not limited to the use of tools or methods that identify increased health status or maintenance of the individual's highest level of functioning, determine the degree of medical access, and reveal recipient satisfaction and habits. Such tools shall include the use of client surveys, anecdotal information, complaint and grievance data, and disenrollment information. The MCE shall annually submit a care management report to the state department that describes techniques used by the MCE to provide more efficient use of health care services, better health status for populations served, and better health outcomes for individuals.

(k) Except as provided in paragraph (m) of this subsection (1), for capitation payments effective on and after July 1, 2003, an MCE that is contracting for a defined scope of services under a risk contract shall certify the financial stability of the MCE pursuant to criteria established by the division of insurance and shall certify, as a condition of entering into a contract with the state department, that the capitation payments set forth in the contract between the 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 covered in the contract.

(l) Except as provided in paragraph (m) of this subsection (1), for capitation payments effective on and after July 1, 2003, an MCE that is contracting for a defined scope of services under a risk contract shall certify, through a qualified actuary retained by the MCE, that the capitation payments set forth in the contract between the MCE and the state department comply with all applicable federal and state requirements that govern said capitation payments. For purposes of this paragraph (l), a "qualified actuary" means a person deemed as such by rule promulgated by the commissioner of insurance.

(m) An MCO providing services under the PACE program as described in section 25.5-5-412 shall certify that the capitation payments are in compliance with applicable federal and state requirements that govern said capitation payments and that the capitation payments are sufficient to ensure the financial viability of the MCO with respect to the delivery of services to the PACE program participants covered in the contract.

(n) The MCE shall ensure, to the extent that voluntary enrollment into the MCE is possible, that the MCE has not provided to a recipient any premiums or other inducements in exchange for the recipient selecting the MCE for coverage.

(o) The MCE has established a grievance procedure pursuant to the provisions in section 25.5-5-406 (1) (b) that allows for the timely resolution of disputes regarding the

quality of care, services to be provided, and other issues raised by the recipient. Matters shall be resolved in a manner consistent with the medical needs of the individual recipient. The MCE shall notify all recipients involved in a dispute with the MCE of their right to seek an administrative review of an adverse decision made by the MCE pursuant to section 25.5-1-107.

(p) With respect to pregnant women and infants, the MCE shall comply with the following:

(I) With the exception of BHOs, enrollment of pregnant women without restrictions and including an assurance that the health care provider shall provide timely access to initiation of prenatal care in accordance with practice standards;

(II) With the exception of BHOs, coverage without restrictions for newborns, including all services such as, but not limited to, preventive care, screening, and well-baby examinations during the first month of life;

(III) With the exception of BHOs, the imposition of performance standards and the use of quality indicators with respect to perinatal, prenatal, and postpartum care for women and birthing and neonatal care for infants. The standards and indicators shall be based on nationally approved guidelines.

(IV) With the exception of BHOs, follow-up basic health maintenance services for women and children, including immunizations and early periodic screening, diagnosis, and treatment services for children and appropriate preventive care services for women.

(q) The MCE shall accept all enrollees regardless of health status.

(r) The MCE shall comply with disclosure requirements as established by the state department and the state board.

(s) The MCE shall provide a mechanism whereby a prescribing physician can request to override restrictions to obtain medically necessary, off-formulary prescription drugs, supplies, equipment, or services for his or her patient.

(t) The MCE shall maintain a network of providers sufficient to ensure that all services to recipients will be accessible without unreasonable delay. The state department shall develop explicit contract standards, in consultation with stakeholders, to assess and monitor the MCE's criteria. Sufficiency shall be determined in accordance with the requirements of this paragraph (t) and may be established by reference to any reasonable criteria used by the MCE, including but not limited to the following:

(I) Geographic accessibility in regard to the special needs of recipients;

(II) Waiting times for appointments with participating providers;

(III) Hours of operation;

(IV) Volume of technological and specialty services available to serve the needs of recipients requiring technologically advanced or specialty care.

(u) (I) For the delivery of prescription drug benefits to recipients enrolled in an MCE who are residents of a nursing facility, MCEs that provide prescription drug benefit services shall use pharmacies with a demonstrated capability of providing prescription

drugs in a manner consistent with the needs of clients in institutional settings such as nursing facilities. In cases where a nursing facility and a pharmacy have a contract for a single pharmacy delivery system for residents of the nursing facility:

(A) An MCE providing prescription drug benefits for residents of the nursing facility shall agree to contract with that pharmacy under reasonable contract terms; and

(B) The pharmacy shall agree to contract with each MCE that provides prescription drug benefits for residents of the nursing facility under reasonable contract terms.

(II) Any disputes concerning providing prescription drug benefits between nursing facilities, pharmacies, and MCEs that cannot be resolved through good faith negotiations may be resolved through a party requesting an informal review by the state department.

(III) The state board shall adopt rules requiring MCEs that provide prescription drug benefit services to contract with qualified pharmacy providers in a manner permitting a nursing facility to continue to comply with federal medicaid requirements of participation for nursing facilities. Such rules shall define "qualified pharmacy providers" and shall be based upon consultations with nursing facilities, MCEs, pharmacies, and medicaid clients. The state department shall provide MCEs with a list of pharmacies that have a contract with nursing facilities serving recipients in nursing facilities in each county in which the MCE is contracting with the state department.

(2) The MCE shall seek proposals from each ECP in a county in which the MCE is enrolling recipients for those services that the MCE provides or intends to provide and that an ECP provides or is capable of providing. To assist MCEs in seeking proposals, the state department shall provide MCEs with a list of ECPs in each county. The MCE shall consider such proposals in good faith and shall, when deemed reasonable by the MCE based on the needs of its enrollees, contract with ECPs. Each ECP shall be willing to negotiate on reasonably equitable terms with each MCE. ECPs making proposals under this subsection (2) must be able to meet the contractual requirements of the MCE. The requirements of this subsection (2) shall not apply to an MCE in areas in which the MCE operates entirely as a group model health maintenance organization.

(3) In selecting MCEs, the state department shall not penalize an MCE for paying cost-based reimbursement to federally qualified health centers as defined in the "Social Security Act".

(4) (a) Notwithstanding any waivers authorized by the federal department of health and human services, or any successor agency, each contract between the state department and an MCE selected to participate in the statewide managed care system under this part 4 shall comply with the requirements of 42 U.S.C. sec. 1396a (a) (23) (B).

(b) Each MCE shall advise its enrollees of the services available pursuant to this subsection (4).

(5) Nothing in this part 4 shall be construed to create an exemption from the applicable provisions of title 10, C.R.S.

(6) Nothing in this part 4 shall be construed to create an entitlement to an MCE to contract with the state department.

25.5-5-405. Quality measurements. (1) The state department shall measure quality pursuant to the following criteria:

(a) Quality shall be measured and considered based upon individuals and groups with the satisfaction of the service received analyzed and compared to nonrecipient populations for the same or similar services when available.

(b) Quality shall focus on health status or maintenance of the individual's highest level of functioning, without strict adherence to statistical norms.

(2) The state board shall promulgate rules to clarify and administer quality measurements.

25.5-5-406. Required features of managed care system. (1) **General features.** All medicaid managed care programs shall contain the following general features, in addition to others that the state department and the state board consider necessary for the effective and cost-efficient operation of those programs:

(a) **Recipient selection of MCEs.** (I) The state department shall, to the extent it determines feasible, provide medicaid-eligible recipients a choice among competing MCEs. MCEs shall provide enrollees a choice among providers within the MCE. Consistent with federal requirements and rules promulgated by the state board, the state department is authorized to assign a medicaid recipient to a particular MCE or PCCM if:

(A) The state department determines that no other MCE or PCCM has the capacity or expertise necessary to serve the recipient; or

(B) A recipient does not respond within thirty days after the date of a notification of a request for selection of an MCE or PCCM.

(II) The state department shall inform recipients of the choices available in their area by appropriate sources of information and counseling. This may include an independent, objective facilitator acting under the supervision of the state department. The state department may contract for the facilitator through a competitive bidding process. This function shall ensure that consumers have informed choice among available options to assure the fullest possible voluntary participation in managed care. The state department, in conjunction with the state board, shall adopt rules setting forth minimum disclosure requirements for all MCEs and PCCMs. Once a recipient is enrolled in an MCE or PCCM, the recipient may not change to a different MCE or PCCM for a period of twelve months; except that the recipient may disenroll without good cause during the first ninety days of enrollment or any time thereafter for good cause as determined by the state department. Good cause shall include, but need not be limited to, administrative

error and an MCE's or PCCM's inability to provide its covered services to a recipient after reasonable efforts on the part of the MCE or PCCM and the recipient, as defined by the state board. Based upon its assessment of any special needs of recipients with cognitive disabilities, the state board may adopt rules relating to any necessary good cause provisions for recipients with cognitive disabilities who are assigned to a particular MCE or PCCM pursuant to subparagraph (I) of this paragraph (a).

(III) When eligible consumers choose to change or disenroll from their selected MCE or PCCM, the state department shall monitor and gather data about the reasons for disenrolling, including denial of enrollment or disenrollment due to an act or omission of an MCE or PCCM. The state department shall analyze this data and provide feedback to the plans or providers and shall use the information in the state department's contracting and quality assurance efforts. Persons who have been denied enrollment or have disenrolled due to an act or omission of an MCE or PCCM may seek review by an independent hearing officer, as provided for and required under federal law and any state statute or rule.

(b) **Complaints and grievances.** Each MCE or PCCM shall utilize a complaint and grievance procedure and a process for expedited reviews that comply with rules established by the state board. The complaint and grievance procedure shall provide a means by which enrollees may complain about or grieve any action or failure to act that impacts an enrollee's access to, satisfaction with, or the quality of health care services, treatments, or providers. The state department shall establish the position of ombudsman for medicaid managed care. It is the intent of the general assembly that the ombudsman for medicaid managed care be independent from the state department and selected through a competitive bidding process. In the event the state department is unable to contract with an independent ombudsman, an employee of the state department may serve as the ombudsman for medicaid managed care. The ombudsman shall, if the enrollee requests, act as the enrollee's representative in resolving complaints and grievances with the MCE or PCCM. The process for expedited reviews shall provide a means by which an enrollee may complain and seek resolution concerning any action or failure to act in an emergency situation that immediately impacts the enrollee's access to quality health care services, treatments, or providers. An enrollee shall be entitled to designate a representative, including but not limited to an attorney, the ombudsman for medicaid managed care, a lay advocate, or the enrollee's physician, to file and pursue a grievance or expedited review on behalf of the enrollee. The procedure shall allow for the unencumbered participation of physicians. An enrollee whose complaint or grievance is not resolved to his or her satisfaction by a procedure described in this paragraph (b) or who chooses to forego a procedure described in this paragraph (b) shall be entitled to request a second-level review by an independent hearing officer, further judicial review, or both, as provided for by federal law and any state statute or rule. The state department may also provide by rule for arbitration as an optional alternative to the complaint and

grievance procedure set forth is this paragraph (b) to the extent that such rules do not violate any other state or federal statutory or constitutional requirements.

(c) **Billing medicaid recipients.** Notwithstanding any federal regulations or the general prohibition of section 25.5-4-301 against providers billing medicaid recipients, a provider may bill a medicaid recipient 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 PCCM.

(d) **Marketing.** In marketing coverage to medicaid recipients, all MCEs shall comply with all applicable provisions of title 10, C.R.S., regarding health plan marketing. The state board is authorized to promulgate rules concerning the permissible marketing of medicaid managed care. The purposes of such rules shall include but not be limited to the avoidance of biased selection among the choices available to medicaid recipients.

(e) **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:

(I) The MCE shall supply participating providers who may prescribe prescription drugs for MCE enrollees with a current copy of such formulary or other access restrictions, including information about coverage, payment, or any requirement for prior authorization; and

(II) The MCE shall provide to all medicaid recipients 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, including information about such formulary or other access restrictions and procedures for gaining access to prescription drugs, including off-formulary products.

(f) **Access to prescription drugs.** (I) The state department shall encourage an MCE to solicit competitive bids for the prescription drug benefit and discourage an MCE that has prescription drugs as a covered benefit from contracting for the prescription drug benefit with a sole source provider as much as possible. The state department's reports required by section 25.5-5-410 shall include a summary of each MCE's pharmacy network by geographic catchment area.

(II) If an MCE solicits competitive bids for the prescription drug benefit, the MCE shall request bids from each pharmacy provider located in the geographic areas in which the MCE is soliciting bids. All MCEs shall follow a reasonable standard for recipient access to prescription drugs. At a minimum, the state department shall verify compliance with these requirements by reviewing evidence provided by the commissioner of insurance concerning compliance with any standards or guidance established by the commissioner of insurance for consumer access to prescription drugs.

(III) The standards and guidance from the insurance commissioner shall be based

on the following:

(A) Procedures that an MCE shall follow to ensure that pharmacies in rural communities with fewer than twenty-five thousand persons have the opportunity to join retail prescription drug networks if they agree to reasonable contract terms;

(B) Procedures that an MCE shall follow to notify the pharmacy community of competitively bid prescription drug contracts;

(C) Procedures that an MCE shall follow to give all pharmacies and pharmacy networks a fair opportunity to participate in prescription drug contracts;

(D) Any related matters that are designed to expand consumer access to pharmacy services; and

(E) Any related matters that will enhance the functioning of the free market system with respect to pharmacies.

(IV) Nothing in this paragraph (f) shall apply to the delivery of prescription drug benefits to recipients enrolled in an MCE who are residents of a nursing facility or to the delivery of medicare part D prescription drugs to recipients who are eligible for such drugs.

(g) **Continuity of care.** (I) New enrollees, with special needs as defined by the state board and as certified by a non-plan physician, may continue to see a non-plan provider for sixty days from the date of enrollment in an MCE, if the enrollee is in an ongoing course of treatment with the previous provider and only if the previous provider agrees:

(A) To accept reimbursement from the MCE as payment in full at rates established by the MCE that shall be no more than the level of reimbursement applicable to similar providers within the MCE's group or network for such services;

(B) To adhere to the MCE's quality assurance requirements and to provide to the MCE necessary medical information related to such care; and

(C) To otherwise adhere to the MCE's policies and procedures including but not limited to procedures regarding referrals, obtaining pre-authorizations, and MCE-approved treatment plans.

(II) New enrollees who are in their second or third trimester of pregnancy may continue to see their practitioner until the completion of postpartum care directly related to the delivery only if the practitioner agrees:

(A) To accept reimbursement from the MCE as payment in full at rates established by the MCE that shall be no more than the level of reimbursement applicable to similar providers within the MCE's group or network for such services;

(B) To adhere to the MCE's quality assurance requirements and to provide to the MCE necessary medical information related to such care; and

(C) To otherwise adhere to the MCE's policies and procedures including but not limited to procedures regarding referrals, obtaining pre-authorizations, and MCE-approved treatment plans.

(III) New enrollees with special needs as defined by the state department may continue to see ancillary providers at the level of care received prior to enrollment for a period of up to seventy-five days. The terms and conditions, including reimbursement rates, shall remain the same as prior to enrollment if the provider and enrollee agree to work in good faith with the MCE toward a transition.

(IV) This paragraph (g) shall not be construed to require an MCE to provide coverage for benefits not otherwise covered.

(2) (a) After January 1, 2015, the state department shall open for competitive bid the state department's medicaid coordinated care system within regions of the state. Before issuing a request for proposal, the state department shall analyze the regions of the state to determine the appropriate number of care coordination regions that should be created. Further, before issuing a request for proposal, the state department shall also analyze the appropriate number of care coordination contracts in each region of the state.

(b) Nothing in this subsection (2) shall delay the implementation of the medicaid payment reform and innovation pilot program created in section 25.5-5-415.

25.5-5-407. State department recommendations - primary care physician program. (1) The primary care physician program requires medicaid recipients to select a primary care physician who is solely authorized to provide primary care and referral to all necessary specialty services. To encourage low-cost and accessible care, the state department is authorized to utilize the primary care physician program to deliver services to appropriate medicaid recipients.

(2) The state department shall establish procedures and criteria for the cost-effective operation of the primary care physician program, including but not limited to such matters as appropriate eligibility criteria and geographic areas served by the programs.

25.5-5-407.5. Prepaid inpatient health plan agreements - rules. (1) Subject to the receipt of any required federal authorizations, pursuant to the requirements of this section, the state department may enter into prepaid inpatient health plan agreements, referred to in this section as a "PIHP agreement", with an entity that:

(a) Provides medical services to enrollees on the basis of prepaid capitation payments, or other payment arrangements that do not use payment rates contained in the state plan; and

(b) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees.

(1.5) Repealed.

(2) (a) A PIHP agreement may include a provision for a quality incentive payment

that is distributed to the contractor within a reasonable period of time, as specified in the contract, following the end of each fiscal year if the contractor substantially exceeds predetermined quality indicators. The quality indicators shall be based upon broadly accepted measures of performance adopted by rule of the state board and agreed upon at the outset of the contract period, and shall include, but need not be limited to, the health plan employers data and information set measures. The quality incentive payment may be made proportional if the state board establishes multiple quality measurements. The quality incentive payments shall not exceed the total cost savings created under the PIHP agreement, as determined by comparison of the PIHP members with an actuarially equivalent fee-for-service population, and the quality incentive payment shall not exceed five percent of the total medicaid payments received by the contractor during the performance period of the PIHP agreement.

(b) (I) Except as provided for in subparagraph (II) of this paragraph (b), the contractor shall distribute at least seventy-five percent of the incentive payment to providers with which it has contracted to serve medicaid recipients.

(II) Subparagraph (I) of this paragraph (b) shall not apply to a contractor that has an exclusive contract with a single medical group in a specific geographic area to provide or arrange for health care services for its members, such as a multi-specialty group model. Such a contractor shall negotiate the distribution of the qualified incentive payment with the medical group.

(3) Subject to the approval of the state board, a PIHP agreement may also provide for an increase in the fee paid to the contractor in an amount reasonably calculated to cover the costs of collecting and maintaining the medical records of recipients through an electronic medical records system.

(4) Nothing in this section shall prevent, to the extent possible, a government-owned entity from using certified public expenditure or other federally recognized financing mechanisms to provide the state share for the federal match to enhance capitation payments up to or above the one hundred percent limit contained in section 25.5-5-408 (9). The state shall not be obligated to increase any general fund expenditures because of the use of certified public expenditure or other federally recognized financing mechanism pursuant to this subsection (4).

25.5-5-407.7. Disability care coordination organization - rules. (Repealed)

25.5-5-408. Capitation payments - availability of base data - adjustments - rate calculation - capitation payment proposal - preference - assignment of medicaid recipients. (1) (a) (I) The state department shall make capitation payments to MCEs based upon a defined scope of services under a risk contract.

(II) Repealed.

(b) A certification by a qualified actuary retained by the state department shall be conclusive evidence that the state department has correctly calculated the direct health care cost of providing these same services on an actuarially equivalent Colorado medicaid population group consisting of unassigned recipients and recipients in the primary care physician program provided in section 25.5-5-407.

(c) Except as otherwise provided in paragraph (d) of this subsection (1) and where the state department has instituted a program of competitive bidding provided in section 25.5-5-402 (3), the state department may utilize a market rate set through the competitive bid process for a set of defined services. The state department shall only use market rate bids that do not discriminate and are adequate to assure quality and network sufficiency. A certification of a qualified actuary, retained by the state department, to the appropriate lower limit shall be conclusive evidence of the state department's compliance with the requirements of this paragraph (c). For the purposes of this subsection (1), a "qualified actuary" shall be a person deemed as such under rules promulgated by the commissioner of insurance.

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

(2) The state department shall develop capitation rates for MCEs contracting for a defined scope of services under a risk contract that include risk adjustments, reinsurance, or stop-loss funding methods. Payments to plans may vary when it is shown through diagnoses or other relevant data that certain populations are expected to cost more or less than the capitated population as a whole.

(3) The state board, in consultation with recognized medical authorities, shall develop a definition of special needs populations that includes evidence of diagnosed or medically confirmed health conditions. The state department shall develop a method for adjusting payments to plans for such special needs populations when diagnoses or other relevant data indicates these special needs populations would cost significantly more than similarly capitated populations.

(4) Under no circumstances shall the risk adjustments, reinsurance, or stop-loss methods developed by the state department pursuant to subsection (2) of this section cause the average per capita medicaid payment to a plan to be greater than the projected medicaid expenditures for treating medicaid enrollees of that plan under fee-for-service medicaid.

(5) The state department may develop quality incentive payments to recognize superior quality of care or service provided by a managed care plan.

(6) Within thirty days from the beginning of each fiscal year, the state department, in cooperation with the MCEs, shall set a timeline for the rate-setting process for the following fiscal year's rates and for the provision of base data to the MCEs that is used in

the calculation of the rates, which shall include but not be limited to the information included in subsection (7) of this section.

(7) The state department shall identify and make available to the MCEs the base data used in the calculation of the direct health care cost of providing these same services on an actuarially equivalent Colorado medicaid population group consisting of unassigned recipients and recipients in the primary care physician program provided in section 25.5-5-407. The state department shall consult with the MCEs regarding any and all adjustments in the base data made to arrive at the capitation payments.

(8) For capitation payments effective on and after July 1, 2003, the state department shall recalculate the base calculation every three years. The three-year cycle for the recalculation of the base calculation shall begin with capitation payments effective for fiscal year 2003-04. In the years in which the base calculation is not recalculated, the state department shall annually trend the base calculation after consulting with the MCEs. The state department shall take into consideration when trending the base calculation any public policy changes that affect reimbursement under the "Colorado Medical Assistance Act".

(9) The rate-setting process referenced in subsection (6) of this section shall include a time period after the MCEs have received the direct health care cost of providing these same services on an actuarially equivalent Colorado medicaid population group consisting of unassigned recipients and recipients in the primary care physician program provided in section 25.5-5-407, for each MCE to submit to the state department the MCE's capitation payment proposal, which shall not exceed one hundred percent of the direct health care cost of providing these same services on an actuarially equivalent Colorado medicaid population group consisting of unassigned recipients and recipients in the primary care physician program provided in section 25.5-5-407. The state department shall provide to the MCEs the MCE's specific adjustments to be included in the calculation of the MCE's proposal. Each MCE's capitation payment proposal shall meet the requirements of section 25.5-5-404 (1) (k) and (1) (l).

(10) For capitation payments effective on and after July 1, 2003, unless otherwise required by federal law, the state department shall certify, through a qualified actuary retained by the state department, that the capitation payments set forth in the contract between the state department and the MCEs comply with all applicable federal and state requirements that govern said capitation payments.

(11) Effective on and after July 1, 2003, the capitation payments certified by the qualified actuary under subsection (10) of this section shall not be subject to any dispute resolution process, including any such process set forth in any settlement agreement entered into prior to July 1, 2002.

(12) Nothing in this section shall prevent, to the extent possible, an MCE that is also a government-owned entity from using certified public expenditure or other federally recognized financing mechanisms to provide the state share for the federal match to

enhance capitation payments up to or above the one hundred percent limit contained in subsection (9) of this section. The state shall not be obligated to increase any general fund expenditures because of the use of certified public expenditure or other federally recognized financing mechanism pursuant to this subsection (12).

25.5-5-409. State department - privatization. (1) The general assembly finds that the statewide managed care system is a program under which the private sector has a great deal of experience in making various health care plans available to the private sector and serving as the liaison between large employers and health care providers, including but not limited to health maintenance organizations. The general assembly therefore determines that a statewide managed care system involves duties similar to duties currently or previously performed by state employees but is different in scope and policy objectives from the state medical assistance program.

(2) To that end, pursuant to section 24-50-504 (2) (a), C.R.S., the state department shall enter into personal services contracts that create an independent contractor relationship for the administration of not less than twenty percent of the statewide managed care system. The state department shall enter into personal service contracts for the administration of the managed care system according to the implementation of the statewide managed care system in accordance with section 25.5-5-402.

(3) The implementation of this section is contingent upon:

(a) Legislative review of the cost-effectiveness of privatization and the extent to which such privatization enhances the quality of care to recipients; and

(b) A finding by the state personnel director that any of the conditions of section 24-50-504 (2), C.R.S., have been met or that the conditions of section 24-50-503 (1), C.R.S., have been met.

25.5-5-410. Data collection for managed care programs - reports. (1) In addition to any other data collection or reporting requirements set forth in this article and articles 4 and 6 of this title, the state department shall access and compile data concerning health data and outcomes. In addition, no later than July 1, 1998, the state department shall conduct or shall contract with an independent evaluator to conduct a quality assurance analysis of each managed care program in the state for medical assistance recipients. No later than July 1, 1999, and each fiscal year thereafter, the state department, using the compiled data and results from the quality assurance analysis, shall submit a report to the house and senate committees on health and human services, or any successor committees, on the cost-efficiency of each managed care program or component thereof, with recommendations concerning statewide implementation of the respective programs or components. For the purposes of this subsection (1), "quality assurance" means costs

weighed against benefits provided to consumers, health outcomes or maintenance of the individual's highest level of functioning, and the overall change in the health status of the population served. The state department's report shall address capitation, including methods for adjusting rates based on risk allocations, fees-for-services, copayments, chronically ill populations, long-term care, community-supported services, and the entitlement status of medical assistance. The state department's report shall include a comparison of the effectiveness of the MCE program and the PCCM program based upon common performance standards that shall include but not be limited to recipient satisfaction.

(2) In addition, the state department of human services, in conjunction with the state department, shall continue its existing efforts, which include obtaining and considering consumer input, to develop 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 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 outcomes based on statistics maintained on individual consumers as well as the total consumer populations served;
- (c) Consumer satisfaction;
- (d) Consumer utilization;
- (e) Health status of consumers; and
- (f) Uncompensated care delivered.

25.5-5-411. Medicaid community mental health services - legislative declaration - administration - rules. (1) The general assembly hereby finds, determines, and declares that:

(a) There is an urgent need to address the economic, social, and personal costs to the state of Colorado and its citizens of untreated mental health and substance use disorders;

(b) Behavioral health disorders, including mental health and substance use disorders, are treatable conditions not unlike other chronic health issues that require a combination of behavioral change and medication or other treatment. When individuals

receive appropriate prevention, early intervention, treatment, and recovery services, they can live full, productive lives.

(c) Untreated behavioral health disorders place individuals at high risk for poor health outcomes and significantly affect virtually all aspects of local and state government by reducing family stability, student achievement, workforce productivity, and public safety;

(d) Currently, there is no single behavioral health care system in Colorado. Instead, consumers of all ages with behavioral health disorders receive services from a number of different systems, including the health care, behavioral health care, child welfare, juvenile and criminal justice, education, and higher education systems.

(e) Adult and youth consumers and their families need quality behavioral health care that is individualized and coordinated to meet their changing needs through a comprehensive and integrated system;

(f) Timely access through multiple points of entry to a full continuum of culturally responsive services, including prevention, early intervention, crisis response, treatment, and recovery, is necessary for an effective integrated system;

(g) Evidence-based and promising practices result in favorable outcomes for Colorado's adult and youth consumers, their families, and the communities in which they live;

(h) Lack of public awareness regarding behavioral health issues creates a need for public education that emphasizes the importance of behavioral health as part of overall health and wellness and creates the desire to invest in and support an integrated behavioral health system in Colorado;

(i) To reduce the economic and social costs of untreated behavioral health disorders, Colorado needs a systemic transformation of the behavioral health system through which transformation the state strives to achieve critical goals to address mental health and substance use disorders; and

(j) The overarching goal of this behavioral health system transformation shall be to make the behavioral health system's administrative processes, service delivery, and funding more effective and efficient to improve outcomes for Colorado citizens.

(2) The general assembly further finds and declares that, to improve the quality of life for the citizens of Colorado, strengthen the economy, and continue the responsible management of the state's resources, the leadership of the three branches of Colorado's state government and the stakeholders most affected by mental health and substance use disorders must collaborate to build on the progress of past efforts and to sustain a focus on the improvement of behavioral health services.

(3) Except as provided for in subsection (6) of this section, the state department shall administer all medicaid community mental health services for medical assistance recipients including but not limited to the prepaid capitated single entry point system for mental health services, the fee-for-service mental health services, and alternatives to

institutionalization. The administration of medicaid community mental health services shall include but shall not be limited to program approval, program monitoring, and data collection.

(4) (a) The requirements of section 25.5-5-408 shall not apply to the capitated rate calculation process for medicaid community mental health services; except that each medicaid community mental health services MCO shall be subject to the requirements of section 25.5-5-404 (1) (k) and (1) (l).

(b) The state department shall establish cost-effective, capitated rates for community mental health services in a manner that includes cost containment mechanisms. These cost containment mechanisms may include, but are not limited to, restricting average per member per month utilization growth, restricting unit cost growth, limiting allowable administrative cost, establishing minimum medical loss ratios, or establishing other cost containment mechanisms that the state department determines appropriate.

(c) Repealed.

(5) The state department is authorized to seek federal approval for any necessary changes to the state's waiver that authorizes the statewide system of community mental health care to reflect the provisions of this section. The state department is authorized to limit a recipient's freedom of choice with respect to a provider of mental health services and to restrict reimbursements for mental health services to designated and contracted agencies in such waiver.

(6) The administration of the mental health institutes shall remain the responsibility of the department of human services.

(7) On and after April 6, 2004, all positions of employment in the department of human services concerning the powers, duties, and functions of administering all medicaid community mental health services for medical assistance recipients transferred to the state department pursuant to this section and determined to be necessary to carry out the purposes of this section by the executive director of the state department shall be transferred to the state department and shall become employment positions therein.

(8) On and after April 6, 2004, all items of property, real and personal, including office furniture and fixtures, computers and software, books, documents, and records of the department of human services pertaining to the duties and functions of administering all medicaid community mental health services for medical assistance recipients are transferred to the state department and shall become the property thereof.

(9) On and after April 6, 2004, for state fiscal year 2003-04, the state department may bill the department of human services medicaid-funded programs division appropriation within the state department's appropriation for the provision of medicaid community mental health services as authorized in this section.

(10) On or before July 1, 2004, the state department and the department of human services shall jointly produce a document to assist mental health consumers and advocates

and providers that participate in Colorado's publicly funded mental health system to understand the respective roles of each department in the provision of mental health services and each department's ability to provide high quality and accessible mental health services. The state department and the department of human services shall make the document available to the public and shall send at least one copy to each community mental health center, statewide mental health advocacy organization, and mental health assessment and services agency. The information contained in the document shall be made available on each department's internet web site. The state department and the department of human services are encouraged to consult with representatives of mental health consumer and provider organizations in the development of the document to ensure that it benefits consumers seeking mental health services and consumers who need to express concerns or complaints regarding the quality, availability, or accessibility of mental health services.

(11) When the state auditor conducts an audit of the statewide mental health system, the state auditor shall evaluate the coordination of services between the state department and the department of human services and the impact of the administration of the mental health system on the quality of care within the statewide mental health system.

(12) The state board shall adopt any rules necessary for the implementation of this section. In adopting rules concerning medicaid community mental health services, the state board shall consider the effect the rules may have on the statewide mental health system.

25.5-5-412. Program of all-inclusive care for the elderly - legislative declaration - services - eligibility - rules. (1) (a) The general assembly hereby finds and declares that it is the intent of this section to replicate the ON LOK program in San Francisco, California, that has proven to be cost-effective at both the state and federal levels. The PACE program is part of a national replication project authorized in section 9412(b)(2) of the federal "Omnibus Budget Reconciliation Act of 1986", as amended, which instructs the secretary of the federal department of health and human services to grant medicare and medicaid waivers to permit not more than ten public or nonprofit private community-based organizations in the country to provide comprehensive health care services on a capitated basis to frail elderly who are at risk of institutionalization. The general assembly finds that, by coordinating an extensive array of medical and nonmedical services, the needs of the participants will be met primarily in an outpatient environment in an adult day health center, in their homes, or in an institutional setting. The general assembly finds that such a service delivery system will enhance the quality of life for the participant and offers the potential to reduce and cap the costs to Colorado of the medical needs of the participants, including hospital and nursing home admissions.

(b) The general assembly finds and declares that the success of the current

provider in providing a service delivery system has enhanced the quality of life for many participants in the PACE program and, therefore, the state should develop additional PACE program sites. The general assembly finds that section 4802 of the federal "Balanced Budget Act of 1997", as amended, allows the state to develop additional PACE program sites. The general assembly further finds that new PACE program sites should be developed using the program developed by the current provider as a model. The general assembly also finds that the state should capitalize on the success, experience, and quality of care of such provider in operating the PACE model by utilizing the provider's technical assistance capabilities. Additionally, the general assembly finds that it is necessary to provide technical assistance to new PACE program sites to ensure consistent quality of services and ultimate success. The general assembly, therefore, encourages the state department to seek grants and donations from national PACE organizations that have received funding to assist states in PACE expansion initiatives and to secure funding to dedicate a full-time staff person to the implementation of this PACE expansion.

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

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

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

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

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

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

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

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

(c) To provide that eligible persons who are frail elderly but who have the capacity to remain in an independent living situation have access to the appropriate social

and health services without which independent living would not be possible;

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

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

(f) Repealed.

(4) Within the context of the PACE program, the state department may include any or all of the services listed in sections 25.5-5-102, 25.5-5-103, 25.5-5-202, and 25.5-5-203, as applicable.

(5) An eligible person may elect to receive services from the PACE program as described in subsection (4) of this section. If such an election is made, the eligible person shall not remain eligible for services or payment through the regular medicare or medicaid programs. All services provided by said programs shall be provided through the PACE program in accordance with this section. An eligible person may elect to disenroll from the PACE program at any time.

(6) The state department, in cooperation with the single entry point agencies established in section 25.5-6-106, 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. These rules shall require additional and on-going training of the single entry point agency case managers in counties where a PACE program is operating. This training shall be provided by a federally approved PACE provider. In addition, each single entry point agency may designate case managers who have knowledge about the PACE program; and

(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.

(6.5) An eligible person who is enrolled in a managed care organization, an organization contracted with the state department pursuant to part 4 of article 5 of this title, or other risk-bearing entity may elect to withdraw from or terminate such enrollment and enroll in and receive services through a PACE program. The state board's rules shall define how such election is made. The effective date of an eligible person's election shall not be more than thirty days after the eligible person's date of election.

(7) For purposes of this section:

(a) "Dually eligible person" means a person who is eligible for assistance or benefits under both medicaid and medicare.

(b) "Eligible person" means a frail elderly individual who voluntarily enrolls in the PACE program and whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, whose resources do not

exceed the limit established by the state department of human services for individuals receiving a mandatory minimum state supplementation of SSI benefits pursuant to section 26-2-204, C.R.S., or in the case of a person who is married, do not exceed the amount authorized in section 25.5-6-101, and for whom a physician licensed pursuant to article 36 of title 12, C.R.S., certifies that such a program provides an appropriate alternative to institutionalized care. "Eligible person" may also include a dually eligible person.

(c) "Frail elderly" means an individual who meets functional eligibility requirements, as established by the state department, for nursing home care and who is fifty-five years of age or older.

(8) Using a risk-based financing model, any nonprofit organization providing the PACE program shall assume responsibility for all costs generated by PACE program participants, and shall create and maintain a risk reserve fund that will cover any cost overages for any participant. The PACE program is responsible for the entire range of services in the consolidated service model, including hospital and nursing home care, according to participant need as determined by the multidisciplinary team. Any nonprofit organization providing the PACE program is responsible for the full financial risk at the conclusion of the demonstration period and when permanent waivers from the federal health care financing administration are granted. Specific arrangements of the risk-based financing model shall be adopted and negotiated by the federal health care financing administration, any nonprofit organization providing the PACE program, and the state department.

(9) Nothing in this section requires a PACE program site operator to hold a certificate of authority as a health maintenance organization under part 4 of article 16 of title 10, C.R.S., for purposes of the PACE program.

(10) (a) The state department shall perform a feasibility study, conditioned on the receipt of sufficient gifts, grants, and donations, in order to identify viable communities that may support a PACE program site. This study shall be completed on or before May 1, 2003.

(b) The state department, consistent with the results of the feasibility study, shall use its best efforts to have in operation:

(I) One additional PACE program site by July 1, 2004;

(II) A total of four additional PACE program sites by July 1, 2005; and

(III) A total of six additional PACE program sites by July 1, 2006.

(c) (I) No later than May 30, 2003, the executive director of the state department shall submit to the joint budget committee of the general assembly and to the health and human services committees of the house of representatives and the senate, or any successor committees, a written report of the results of the feasibility study conducted under paragraph (a) of this subsection (10).

(II) No later than January 1, 2007, the executive director of the state department shall submit to the joint budget committee of the general assembly and to the health and

human services committees of the house of representatives and the senate, or any successor committees, a final written report detailing the expansion of PACE program sites across the state.

(11) The state board shall promulgate such rules, pursuant to article 4 of title 24, C.R.S., as are necessary to implement this section.

(12) (a) The general assembly shall make appropriations to the state department to fund services under this section provided at a monthly capitated rate. The state department shall annually renegotiate a monthly capitated rate for the contracted services.

(b) Repealed.

(13) The state department may accept grants and donations from private sources for the purpose of implementing this section.

25.5-5-413. Direct contracting with providers - legislative declaration. (1) The general assembly hereby finds, determines, and declares that costs associated with providing medical assistance to recipients have increased substantially due in part to increased costs of health care services and higher utilization rates. These cost pressures have been most dramatically demonstrated in the southern area of the state. Therefore, the general assembly finds, determines, and declares that pilot programs should be created to evaluate whether a provider may contract directly with the state department for the provision of services to recipients.

(2) The state department is authorized to contract directly with any provider who is able to demonstrate compliance with state laws and rules pertaining to risk-bearing entities to provide a capitated-risk program on a per member per month basis. The provider shall not serve more than two thousand five hundred recipients. The provider shall accept full risk for each participant, except for transplants or out-of-area services.

(3) The state department is authorized to contract directly with any provider who is able to provide a cost-effective and quality health care system through a capitated partial risk program on a per member per month basis or through any other financial arrangement with the department where the provider manages the health care available to the recipients and shares with the state department the savings associated with management of such health care.

(4) **Selection of the provider.** The state department shall select any provider who:

(a) Is able to provide evidence of a successful history of risk management for recipients;

(b) Initiates direct contracting with the state department; and

(c) Is able to demonstrate compliance with state laws and rules pertaining to risk-bearing entities.

25.5-5-414. Telemedicine - legislative intent. (1) It is the intent of the general assembly to recognize the practice of telemedicine as a legitimate means by which an individual may receive medical services from a health care provider without person-to-person contact with a provider.

(2) For the purposes of this section, "telemedicine" shall have the same meaning as set forth in section 12-36-106 (1) (g), C.R.S.

(3) On or after January 1, 2002, face-to-face contact between a health care provider and a patient shall not be required under the managed care system created in this part 4 for services appropriately provided through telemedicine, subject to reimbursement policies developed by the state department to compensate providers who provide health care services covered by the program created in section 25.5-4-104. Telemedicine services may only be used in areas of the state where the technology necessary for the provision of telemedicine exists. The audio and visual telemedicine system used shall, at a minimum, have the capability to meet the procedural definition of the most recent edition of the current procedural terminology that represents the service provided through telemedicine. The telecommunications equipment shall be of a level of quality to adequately complete all necessary components to document the level of service for the current procedural terminology fourth edition codes that are billed. If a peripheral diagnostic scope is required to assess the patient, it shall provide adequate resolution or audio quality for decision-making.

(4) The state department shall report to the health and human services committees of the house of representatives and the senate, or any successor committees, no later than January 1, 2006, on the application of telemedicine to provide home health care; emergency care; critical and intensive care, including, but not limited to, neonatal care; psychiatric evaluation; psychotherapy; and medical management as potential managed care system benefits. Such report shall take into account the availability of technology as of the time of the report to use telemedicine for home health care, emergency care, and critical and intensive care and the availability of broadband access within the state.

(5) The managed care system shall not be required to pay for consultation provided by a provider by telephone or facsimile machines.

(6) The state department may accept and expend gifts, grants, and donations from any source to conduct the valuation of the cost-effectiveness and quality of health care provided through telemedicine by those providers who are reimbursed for telemedicine services by the managed care system.

(7) Nothing in this section shall be construed to:

- (a) Alter the scope of practice of any health care provider; or
- (b) Authorize the delivery of health care services in a setting or manner not otherwise authorized by law.

25.5-5-415. Medicaid payment reform and innovation pilot program - legislative declaration - creation - selection of payment projects - report - rules. (1) (a) The general assembly finds that:

(I) Increasing health care costs in Colorado's medicaid program creates challenges for the state's budget. Further, the increasing health care costs do not necessarily reflect improvements in either health outcomes for patients or in patient satisfaction with the care received;

(II) Moreover, the fee-for-service payment model may not support or align financially with evolving care coordination and delivery systems;

(III) The reform of medicaid payment policies offers a significant opportunity for the state to contain costs and improve quality;

(IV) New payment methodologies, including global payments, have been developed to respond to rising costs and the complexities of health care delivery. Opportunities now exist to explore, test, and implement such payment reforms in the medicaid program.

(V) The state department should explore how these new payment methodologies may result in improved health outcomes and patient satisfaction and support the financial sustainability of the medicaid program.

(b) Therefore, the general assembly declares that Colorado should build upon ongoing reforms of health care delivery in the medicaid program by implementing a pilot program within the structure of the state department's current medicaid coordinated care system that encourages the use of new and innovative payment methodologies, including global payments.

(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 satisfaction.

(b) (I) The state department shall create a process for interested contractors of the state department's current medicaid coordinated care system to submit payment projects for consideration under the pilot program. Payment projects submitted pursuant to the pilot program may include, but need not be limited to, global payments, risk adjustment, risk sharing, and aligned payment incentives, including, but not limited to, gainsharing, to achieve improved quality and to control costs.

(II) The design of the payment project or projects shall address the client population of the state department's current medicaid coordinated care system and be tailored to the region's health care needs and the resources of the state department's current medicaid coordinated care system.

(III) A contractor of the state department's current medicaid coordinated care system shall work in coordination with the providers and managed care entities contracted with the contractor of the state department's current medicaid coordinated care system in

developing the payment project or projects.

(c) (I) On or before July 1, 2013, the state department shall complete its review of payment projects and shall select payment projects to be included in the pilot program.

(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 satisfaction;

(B) The potential of the payment project to reduce the state's medicaid expenditures;

(C) The state department's ability to ensure that inpatient and outpatient hospital reimbursements are maximized up to the upper payment limits, as defined in 42 CFR 447.272 and 42 CFR 447.321 and calculated by the state department periodically;

(D) The client population served by the state department's current medicaid coordinated care system and the particular health needs of the region;

(E) The business structure or structures likely to foster cooperation, coordination, and alignment and the ability of the contractor of the state department's current medicaid coordinated care system to implement the payment project, including the resources available to the contractor of the state department's current medicaid coordinated care system and the technological infrastructure required; and

(F) The ability of the contractor of the state department's current medicaid coordinated care system to coordinate among providers of physical health care, behavioral health care, oral health care, and the system of long-term care services and supports.

(III) For payment projects not selected by the state department, the state department shall respond to the contractor of the state department's current medicaid coordinated care system, in writing, on or before July 1, 2013, stating the reason or reasons why the payment project was not selected. The state department shall send a copy of the response to the joint budget committee of the general assembly, the health and human services committee of the senate, or any successor committee, and the health and environment committee of the house of representatives, or any successor committee.

(d) (I) The payment projects selected for the program shall be for a period of at least two years, but shall not extend beyond June 30, 2016. The provider contract shall specify the payment methodology utilized in the payment project.

(II) The requirements of section 25.5-5-408 do not apply to the rate-calculation process for payments made to MCEs pursuant to this section.

(III) MCEs participating in the pilot program are subject to the requirements of section 25.5-5-404 (1) (k) and (1) (l), as applicable.

(IV) Payments made to MCEs under the pilot program shall account for prospective, local community or health system cost trends and values, as measured by quality and satisfaction measures, and shall incorporate community cost experience and reported encounter data to the extent possible to address regional variation and improve

longitudinal performance.

(V) Notwithstanding any provisions of this section or state board rules to the contrary, it is the intent of the general assembly that total payments, adjustments, and incentives will be budget-neutral with respect to state expenditures. The state department shall not enter into a contract with a provider pursuant to this section if the state department estimates that total payments to the provider will be greater than without the contract.

(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 satisfaction, and any other data and information necessary to evaluate the efficacy of the payment methodology.

(4) (a) The state department shall submit a report to the joint budget committee of the general assembly, the health and human services committee of the senate, or any successor committee, and the health and environment committee of the house of representatives, or any successor committee, as follows:

(I) On or before February 1, 2013, concerning the design and implementation of the pilot program, including a description of any payment projects received by the state department and the time frame for implementation;

(II) On or before September 15, 2014, concerning the pilot program as implemented, including but not limited to an analysis of the initial data and information concerning the utilization of the payment methodology, quality measures, and the impact of the payment methodology on health outcomes, cost, provider participation and satisfaction, and patient satisfaction; and

(III) On or before September 15, 2015, and each September 15 that the program is being implemented, concerning the program as implemented, including but not limited to an analysis of the data and information concerning the utilization of the payment methodology, including an assessment of how the payment methodology drives provider performance and participation and the impact of the payment methodology on quality measures, health outcomes, cost, provider satisfaction, and patient satisfaction, comparing those outcomes across all patients utilizing existing state department data.

(b) For purposes of evaluating the pilot program and payment methodologies, the state department may collaborate with a nonprofit entity or an institution of higher education to analyze and verify data and information received from pilot participants and to evaluate quality measures and the cost effectiveness of the payment reforms.

(5) The state department shall seek any federal authorization necessary to implement the pilot program.

(6) The state department may promulgate any rules necessary to implement the pilot program.

25.5-5-416. Report concerning efficient contracting in managed care - legislative declaration - repeal. (Repealed)

25.5-5-417. Reducing unnecessary duplicative services in the accountable care collaborative program - repeal. (1) (a) The general assembly finds and declares that:

(I) The state department has created a medicaid coordinated care system known and referred to in this section as the "accountable care collaborative" to improve client health and reduce costs in the medicaid program;

(II) One of the primary goals of the accountable care collaborative is to reduce costs to the medicaid program through coordination between the primary care medical providers, the regional care collaborative organizations, and the statewide data and analytics contractor;

(III) Additionally, the accountable care collaborative is also evaluating the payment system used for the medicaid program to improve client health outcomes through more effective payment systems;

(IV) The state department has entered into contracts with regional organizations for the accountable care collaborative;

(V) These regional care collaborative organizations, referred to in this section as "RCCOs", receive a per-member, per-month payment to perform a number of functions that include but are not limited to supporting community-based care coordination, being accountable for health and cost outcomes, and ensuring care coordination for all clients; and

(VI) Despite care coordination and accountability efforts, there remains within the medicaid system waste and duplication of services that are increasing state medicaid costs and preventing maximum efficiency in the medicaid system.

(b) Therefore, the general assembly declares that, in an effort to bring greater transparency to cost-containment efforts by the accountable care collaborative, the state department shall report annually to the general assembly concerning efforts to reduce waste and duplication within the accountable care collaborative.

(2) As part of the annual report required pursuant to part 2 of article 7 of title 2, C.R.S., the state department shall provide information concerning the following:

(a) The specific efforts within the accountable care collaborative, including a summary of technology-based efforts, to identify and implement best practices relating to cost containment, and reducing avoidable, duplicative, variable, and inappropriate use of health care resources, and the outcome of those efforts, including cost savings if known;

(b) Any statutes or policies or procedures that prevent the RCCOs from realizing efficiencies and reducing waste within the medicaid system; and

(c) Any other efforts by the RCCOs or the state department to ensure that those

who provide care for medicaid clients are aware of and actively participate in reducing waste within the medicaid system.

(3) The state department shall indicate on its report the counties being served by each RCCO.

(4) This section is repealed, effective July 15, 2018.

PART 5

PRESCRIPTION DRUGS

25.5-5-500.3. Authorization to bill third party. As a condition of doing business in the state, each provider is deemed to authorize the state department, or an independent contractor retained by the state department, to bill a third party, as defined in section 25.5-4-209 (2) (g) (II), on behalf of the provider if the third party is determined to be liable to pay for care pursuant to sections 25.5-4-209 and 25.5-4-300.4.

25.5-5-501. Providers - drug reimbursement. (1) (a) As to drugs for which payment is made, the state board's rules for the payment therefor shall include the requirement that the generic equivalent of a brand-name drug be prescribed if the generic equivalent is a therapeutic equivalent to the brand-name drug, except when reimbursement to the state for a brand-name drug makes the brand-name drug less expensive than the cost of the generic equivalent. The state department shall grant an exception to this requirement if the patient has been stabilized on a medication and the treating physician, or a pharmacist with the concurrence of the treating physician, is of the opinion that a transition to the generic equivalent of the brand-name drug would be unacceptably disruptive. The requirements of this subsection (1) shall not apply to medications for the treatment of mental illness, cancer, epilepsy, or human immunodeficiency virus and acquired immune deficiency syndrome.

(b) The provisions of this subsection (1) shall apply to fee-for-service and primary care physician program recipients.

(2) It is the general assembly's intent that requiring the use of a generic equivalent of a brand-name drug will produce savings within the state's medicaid program. The state department, therefore, is authorized to use savings in the medical services premiums appropriations to fund the administrative review process required by subsection (1) of this section.

25.5-5-502. Unused medications - reuse - rules. (1) As used in this section,

unless the context otherwise requires, "medication" means prescription medication that is not a controlled substance.

(2) A pharmacist participating in the medical assistance program may accept unused medication from a licensed facility, as defined in section 12-42.5-133 (1) (a), C.R.S., or a licensed health care provider for the purpose of dispensing the medication to another person. A pharmacist shall reimburse the state department for the cost of medications that the state department has paid to the pharmacist if medications are returned to a pharmacist and the medications are available to be dispensed to another person. Medications shall only be available to be dispensed to another person under this section if the medications are:

- (a) Liquid and the vial is still sealed and properly stored;
- (b) Individually packaged and the packaging has not been damaged; or
- (c) In the original, unopened, sealed, and tamper-evident unit dose packaging.

(3) Medication dispensed pursuant to this section shall bear an expiration date that is later than six months after the date the drug was donated.

(4) Any savings realized through reimbursements received pursuant to subsection (1) of this section shall fund the administration of this section.

(5) The state board, in consultation with the state board of pharmacy, shall adopt rules for the implementation of this section.

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, who are also eligible for medicare, in any federal prescription drug benefit enacted for medicare recipients.

(2) Prescribed drugs shall not be a covered benefit under the medical assistance program for a recipient 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.

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 and articles 4 and 6 of this title 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 authorized in

this article and articles 4 and 6 of this title.

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

(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 and the terms and conditions for pharmaceutical contracts.

25.5-5-505. Prescribed drugs - mail order - rules. (1) (a) (I) The state board shall adopt by rule a system to allow the following medical assistance recipients to receive prescribed maintenance medications through mail order:

(A) Recipients who suffer from a physical hardship that prohibits the recipient from obtaining prescription medications from a local pharmacy; and

(B) Recipients who have third-party insurance that allows the recipient to obtain maintenance medications through mail order.

(II) The state board shall include in the rules the definition of maintenance medications. The rules may allow for a medical assistance recipient who qualifies to receive medication through mail order pursuant to this section to receive up to a three-month supply, or the maximum allowed under federal law, of maintenance medications used to treat chronic medical conditions.

(b) The state board shall, to the extent possible, require the use of local pharmacies that are able to provide the same services as mail order. To the extent allowed by federal law, the state department shall require that the same copayment amount be paid by a medical assistance recipient receiving prescription medication through mail order as a medical assistance recipient receiving prescription medication from a local pharmacy.

(c) A nonresident prescription drug outlet doing business in this state shall provide a means for recipients of state medical assistance who have third-party insurance with whom the nonresident prescription drug outlet has a contractual relationship to receive their required pharmacy benefits at a cost to the recipients of no more than the legally allowed state medical assistance copayment. If a third-party insurance carrier's copayment or deductible for pharmacy benefits is larger than the legally allowed state medical assistance copayment, the prescription drug outlet may bill the state medical assistance program for the difference pursuant to state medical assistance reimbursement rules.

(2) The state department shall seek any federal authorization necessary to implement this section.

25.5-5-506. Prescribed drugs - utilization review. (1) The state department

shall develop and implement a drug utilization review process to assure the appropriate utilization of drugs by patients receiving medical assistance in the fee-for-service and primary care physician programs. The review process shall include the monitoring of prescription information and shall address at a minimum underutilization and overutilization of benefit drugs. Periodic reports of findings and recommendations shall be forwarded to the state department.

(2) It is the general assembly's intent that the implementation of a drug utilization review process for the fee-for-service and primary care physician programs will produce savings within the state's medicaid program. The state department, therefore, is authorized to use savings in the medical services premiums appropriations to fund the development and implementation of a drug utilization review process for these programs, as required by subsection (1) of this section. The state department may contract on a contingency basis for the development or implementation of the review process required by subsection (1) of this section.

(3) (a) The state department shall implement drug utilization mechanisms, including, but not limited to, prior authorization, to control costs in the medical assistance program associated with prescribed drugs. The state board shall promulgate a rule that outlines a process in which any interested party may be notified of and comment on the implementation of any prior authorization for a class of prescribed drugs before the class is prior authorized.

(b) The state department shall report to the health and human services committees for the house of representatives and the senate, or any successor committees, and the joint budget committee no later than December 1, 2003, and each December 1 thereafter, on plan utilization mechanisms that have been implemented or that will be implemented by the state department, the time frames for implementation, the expected savings associated with each utilization mechanism, and any other information deemed appropriate by the health and human services committees, or any successor committees, or the joint budget committee.

25.5-5-507. Prescription drug information and technical assistance program - rules. There is hereby created the prescription drug information and technical assistance program. The program shall provide advice on the prudent use of prescription drugs to persons who receive prescription drug benefits pursuant to this part 5. The state department shall contract with licensed pharmacists for statewide medicaid pharmacy services and pharmacy consultations for persons receiving prescription drug benefits pursuant to this part 5 regarding how each person may, with the approval of the appropriate prescribing health care provider, avoid dangerous drug interactions, improve patient outcomes, and save the state money for the drugs prescribed. The state department shall promulgate rules to establish and administer the program and to provide

incentive payments to pharmacists and physicians who participate in the program. The state department shall design a calculation for savings under the program.

25.5-5-508. Electronic prescriptions - study - report - repeal. (Repealed)

PART 6

PROGRAM FOR TEEN PREGNANCY
AND DROPOUT PREVENTION

25.5-5-601. Legislative declaration. The general assembly finds that the incidences of teen pregnancies in the state raise health issues such as prenatal care, low-weight births, proper immunizations, and other well-care issues and that those health issues result in a significant impact on the state's medical assistance budget. The general assembly also finds that teenagers who become parents have a greater propensity to drop out of school before finishing high school and frequently become an economic burden upon the public assistance program of the state. The general assembly, therefore, declares that the department of health care policy and financing should analyze the feasibility of a teen pregnancy and dropout prevention program that promotes self-sufficiency, self-reliance, and a sense of personal responsibility in teenagers to make appropriate family planning decisions.

25.5-5-602. Definitions. As used in this part 6, unless the context otherwise requires:

(1) "At-risk teenager" means a person under nineteen years of age who resides in a neighborhood in which there is a preponderance of poverty, unemployment and underemployment, substance abuse, crime, school dropouts, a significant public assistance population, teen pregnancies and teen parents, or other conditions that put families at risk.

(2) "Department" means the state department of health care policy and financing.

25.5-5-603. Program - teen pregnancy and dropout prevention. (1) (a) The general assembly authorizes the department to implement a statewide program for teen pregnancy and dropout prevention to serve teenagers who are medicaid recipients. The department shall design a program based upon community support and assistance, percentage of births in the community that have been funded under the state medical

assistance program, the use of program designs that include accurate methods for measuring the effectiveness of the program, and availability of additional federal funds and local or private funding. The department may seek any federal waivers that may be necessary to implement this part 6.

(b) In implementing a statewide program pursuant to paragraph (a) of this subsection (1), the department shall collaborate with the department of public health and environment and may collaborate with other public agencies and nonprofit organizations to promote and expand provider participation in the program. Additionally, the department shall collaborate with the department of education to facilitate the provision of services to at-risk teenagers and teen parents.

(2) (a) The purpose of the program shall be to reduce the incidences of teen pregnancy and school dropouts by providing support services to at-risk teenagers and to teen parents.

(b) Such services may include, but shall not be limited to, the following services or combination of services:

(I) Intensive individual or group counseling, which includes a component on sexual abstinence and delayed parenting;

(II) Vocational, health, and educational guidance;

(III) Public health services such as home visits or visiting nurse services; and

(IV) Instruction concerning human sexuality; except that the department, in providing a teen pregnancy prevention program pursuant to the provisions of this part 6 that provides instruction concerning human sexuality, shall adopt science-based content standards to ensure that any instruction concerning human sexuality that is provided satisfies the requirements of section 22-1-128 (6), C.R.S., as if the program were provided by a school district.

(c) In addition to providing the services described in paragraph (b) of this subsection (2), the department may develop incentives for teen parents who receive public assistance to become self-sufficient and delay further parenting choices.

(2.5) (a) Providers providing services under the program shall collect data relevant to measuring the program's effectiveness by surveying program participants at the beginning of participation, during the program, and at the end of participation concerning certain behaviors that decrease the likelihood of teen pregnancy, including:

(I) Postponing the first sexual encounter;

(II) Reducing the frequency of sexual intercourse;

(III) Reducing the number of sexual partners or maintaining monogamous relationships;

(IV) Increasing the effective use of contraception; and

(V) Reducing the incidence of unprotected sex.

(b) Providers shall provide the department with a summary of the survey results collected pursuant to paragraph (a) of this subsection (2.5) along with information, to the

extent determinable by the provider, concerning the number of participants who, while enrolled in the program or after leaving the program:

- (I) Drop out of school;
- (II) Become pregnant as a teenager; or
- (III) As a teenager, impregnate someone.

(3) The teen pregnancy and dropout prevention program shall be financed with federal funds, local contributions, and any grants or donations from private entities. No general fund moneys shall be used to finance the program; except that the general assembly may appropriate any moneys necessary for the internal administrative costs of the department for providing expanded program promotion and oversight.

25.5-5-604. Report. The department shall report annually to the joint budget committee, the health and environment committee of the house of representatives, or any successor committee, and the health and human services committee of the senate, or any successor committee, concerning the effectiveness of the program. The report shall include at a minimum the number of new providers participating in the program, the number of additional program participants, the pregnancy rate for program participants as compared to the pregnancy rate for medicaid clients of the same age group in the same geographic area, and a summary of the information collected by the department pursuant to section 25.5-5-603 (2.5) concerning participant behaviors that decrease the likelihood of teen pregnancy.

25.5-5-605. Repeal of part. This part 6 is repealed, effective September 1, 2016. Prior to such repeal, the teen pregnancy and dropout prevention program implemented by the department pursuant to this part 6 shall be reviewed as provided in section 24-34-104, C.R.S.

PART 7

TELEMEDICINE PILOT PROGRAMS FOR CHRONIC MEDICAL CONDITIONS

25.5-5-701 to 25.5-5-703. (Repealed)

ARTICLE 6

Colorado Medical Assistance Act -

Long-term Care

PART 1

LONG-TERM CARE ADMINISTRATION

25.5-6-101. Spousal protection - protection of income and resources for community spouse - definitions - amounts retained - responsibility of state department - right to appeal. (1) As used in this section, unless the context otherwise requires:

(a) "Community spouse" means the spouse of a person who is in an institution or nursing facility, the spouse of a person who is enrolled in the PACE program authorized pursuant to section 25.5-5-412, or the spouse of a person who is receiving home- and community-based services pursuant to this article.

(b) "Community spouse monthly income allowance" means the amount by which the minimum monthly maintenance needs allowance exceeds the amount of monthly income that is available to the community spouse.

(c) "Community spouse resource allowance" means the amount of assets, excluding the value of the home and other exempt resources under federal law, that the community spouse shall be allowed to retain and that shall not be available to cover an institutionalized spouse's cost of care.

(d) (I) "Institutionalized spouse" means an individual who is in an institution or nursing facility who is married to a spouse who is not in an institution or nursing facility.

(II) For purposes of this section, "institutionalized spouse" includes an individual who is enrolled in the PACE program authorized pursuant to section 25.5-5-412 or is receiving home- and community-based services pursuant to this article, and who is married to a spouse who is not enrolled in the PACE program or receiving home- and community-based services.

(e) (I) (A) "Minimum monthly maintenance needs allowance" means an amount which is equal to an applicable percent of the nonfarm income official poverty line (increased annually by the consumer price index for all urban consumers), as defined by the federal office of management and budget, for a family unit of two members.

(B) For the purposes of sub-subparagraph (A) of this subparagraph (I), the applicable percent shall be: As of September 30, 1989, one hundred twenty-two percent; as of July 1, 1991, one hundred thirty-three percent; as of July 1, 1992, one hundred fifty percent.

(II) Notwithstanding the provisions of subparagraph (I) of this paragraph (e), the minimum monthly maintenance needs allowance may be increased on an individual basis

if:

(A) The community spouse has shelter and utilities expenses that exceed thirty percent of the minimum monthly maintenance needs allowance; except that the total allowance shall not exceed fifteen hundred dollars (increased annually by the consumer price index for all urban consumers);

(B) Either spouse is responsible for a dependent family member, including children, parents, or siblings who reside with the community spouse; or

(C) The community spouse has exceptional circumstances which would result in significant financial duress.

(2) (a) In order to implement the medical assistance program in compliance with the federal "Medicare Catastrophic Coverage Act of 1988", as amended, the state department shall ensure, when an institutionalized spouse is eligible for medical assistance under this article and articles 4 and 5 of this title, that the community spouse retain a community spouse monthly income allowance but only to the extent that income of the institutionalized spouse is made available to the community spouse.

(b) (I) The resources available to the married couple shall be calculated at the beginning of a continuous period of institutionalization of the institutionalized spouse. The community spouse shall retain the remainder of the couple's countable resources up to the federal maximum resource allowance as a community spouse resources allowance. The institutionalized spouse may keep an amount up to the amount of resources allowed under the federal medicaid program.

(II) Notwithstanding the provisions of subparagraph (I) of this paragraph (b), if either spouse establishes that the community spouse resource allowance is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, an amount adequate to provide the minimum monthly maintenance needs allowance shall be substituted.

(3) The state board shall have the authority to promulgate any rules that are necessary to implement the provisions of this section in accordance with the federal "Medicare Catastrophic Coverage Act of 1988", as amended. The rules adopted by the state board shall include, as a minimum, provisions regarding the following matters:

(a) The treatment of a married couple's income and resources before and after eligibility for medical assistance is established, including the basis for dividing such income and resources between the two parties;

(b) The process for appealing any determinations regarding income and resources that are made pursuant to these rules.

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:

(a) The state makes significant expenditures for nursing home care under the "Colorado Medical Assistance Act";

(b) A large number of persons do not have enough income to afford nursing home care, but have too much income to qualify for state medical assistance, a situation popularly referred to as the "Utah gap";

(c) Some persons in the Utah gap, through innovative court-approved trust arrangements, have become qualified for state medical assistance, thereby increasing state medical assistance expenditures;

(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 treated the same as any other recipient of medical assistance for nursing home care;

(e) In enacting this section, the general assembly intends only to limit certain court-approved trusts and court-approved transfers of property. It is not the general assembly's intent to approve or disapprove of privately created trusts or private transfers of property made under the same or similar circumstances.

(2) The county department shall verify that an applicant for medical assistance for nursing home care, pursuant to the provisions of this title, meets applicable eligibility criteria for assistance other than those set forth in subsection (3) of this section. Upon verification, for eligibility purposes and in accordance with subsection (3) of this section, the county department shall make a determination of the status of any court-approved trust established for or court-approved transfer of property made by or for the applicant.

(3) (a) If a person who applies for medical assistance for nursing home care would be deemed ineligible for assistance as a result of deeming a court-approved trust established for the applicant as a medicaid qualifying trust or as a result of deeming property in the court-approved trust as an improper transfer of assets, the person's application shall, nonetheless, be treated as a case of undue hardship and the person shall be eligible for medical assistance for said care if the establishment of the court-approved trust meets the following criteria:

(I) The applicant's monthly gross income from all sources, without reference to the court-approved trust, exceeds the income eligibility standard for medical assistance then in effect but is less than the average private pay rate for nursing home care for the geographic region in which the applicant lives;

(II) The property used to fund the trust shall be limited to monthly unearned income owned by the applicant, including any pension payment;

(III) The applicant and the state medical assistance program shall be the sole beneficiaries of the trust. The entire corpus of the trust, or as much of the corpus as may be distributed each month without violating federal requirements for federal financial participation, shall be distributed each month for expenses related to the beneficiary's

nursing home care that are approved under the medical assistance program; except that an amount reasonably necessary to maintain the existence of the trust and to comply with federal requirements may be retained in the trust. Deductions may be distributed from the trust to the same extent deductions from the income of a nursing home resident who is not a trust beneficiary are allowed under the medical assistance program, which shall include the following:

- (A) A monthly personal needs allowance;
 - (B) Payments to the beneficiary's community spouse or dependent family members as provided and in accordance with Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396r-5, as amended, and section 25.5-6-101;
 - (C) Specified health insurance costs and special medical services provided under Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396a(r), as amended; and
 - (D) Any other deduction provided in the rules of the state department.
- (IV) Upon the death of the beneficiary, a remainder interest in the corpus of the trust shall pass to the state agency responsible for administering the state medical assistance program;
- (V) The trust shall not be subject to modification by the beneficiary or the trustee unless otherwise provided by this section or section 15-14-412.5, C.R.S.
- (b) For the purposes of this subsection (3), "medicaid qualifying trust" shall have the same meaning as set forth in Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396a(k).
- (4) The state board shall adopt rules as are necessary for the implementation of this section and as are necessary to comply with federal law. In addition, the state department shall amend the state medical assistance plan in a manner that is consistent with the provisions of this section.
- (5) This section shall take effect January 1, 1992, and shall apply to any court-approved trust established for or court-approved transfer of property made by or for a protected person applying for or receiving medical assistance for nursing home care pursuant to the provisions of this title, on or after said date; except that a court-approved trust created before said date that does not comply with this section shall be modified to comply with this section no later than July 1, 1992, before which time the court-approved trust or court-approved transfer of property to a trust shall not render the protected person ineligible for medical assistance.
- (6) The provisions of this section shall not apply if federal funds are not available for persons who would qualify for medical assistance as a result of a court-approved trust that meets the criteria set forth in this section.
- (7) This section shall apply to trusts established or transfers of property made prior to July 1, 1994. The provisions set forth in sections 15-14-412.6 to 15-14-412.9, C.R.S., and any rules adopted by the state board pursuant to section 25.5-6-103 shall apply to trusts established or property transferred on or after that date.

25.5-6-103. Court-approved trusts - transfer of property for persons seeking medical assistance - rule-making authority for trusts created on or after July 1, 1994 - undue hardship. (1) The state board shall adopt such rules as are necessary with respect to trusts established pursuant to sections 15-14-412.6 to 15-14-412.9, C.R.S. The state board shall adopt rules that address, but need not be limited to, the following:

(a) The definition, including any limitations, of permissible distributions from trusts, taking federal guidelines into consideration;

(b) Reasonable financial reimbursement or incentives to the state department, county departments of social services, and any other designated agencies for the efforts and expenses in monitoring trusts, and where necessary, for the recovery of trust property that has been improperly distributed or otherwise expended.

(2) The state board shall comply with Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396p (d) (5), as amended, which requires the state medicaid agency to establish procedures, in accordance with standards specified by the secretary of the United States department of health and human services, under which the state medicaid agency may waive the application of the general rules for considering trust property in determining eligibility for medical assistance if the applicant for medical assistance establishes that the application of the general rules would work an undue hardship on the individual.

(3) The state department shall determine the feasibility of providing ongoing support of dependents by using the trust corpus during the life of the person for whom a trust is created or using the remainder of the trust after the death of the person for whom the trust was created. If the state department determines that it is feasible to provide that support, the state department shall seek a waiver from the federal government to permit the use of trust property for that purpose.

25.5-6-104. Long-term care placements - comprehensive and uniform client assessment instrument - legislative declaration - definitions. (1) (a) The general assembly hereby finds, determines, and declares that there is an increasing strain on long-term care services in the state; that the number of persons in need of long-term care continues to grow; that community-based resources are not integrated into a centralized system for referrals, assessment of needs, development of care plans, and case management; and that persons in need of long-term care services have difficulty accessing and using the current system, which is fragmented and which results in inappropriate placements.

(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 entry, assessment of need, and service delivery into a single unified system; and that such

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 at the local level, that is available to all persons 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:

(a) "Activities of daily living" means the basic self-care activities, including eating, bathing, dressing, transferring from bed to chair, bowel and bladder control, and independent ambulation.

(b) "Case management services" means the assessment of a long-term care client's needs, the development and implementation of a care plan for such client, the coordination and monitoring of long-term care service delivery, the direct delivery of services as provided by this article or by rules adopted by the state board pursuant to this article, the evaluation of service effectiveness, and the reassessment of such client's needs, all of which shall be performed by a single entry point as defined in paragraph (k) of this subsection (2).

(c) "Community-based" means services provided in an individual's home or in a homelike setting. "Community-based" does not include a hospital, hospital unit, nursing facility, or nursing home.

(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 functional capacity, to determine the social and medical needs of a current or potential client 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 has access and which enables a client 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 inquiries.

(g) "Instrumental activities of daily living" means home management and independent living activities such as cooking, cleaning, using a telephone, shopping, doing laundry, providing transportation, and managing money.

(h) "Long-term care" means those services designed to provide diagnostic, preventive, therapeutic, rehabilitative, supportive, and maintenance services for individuals who have chronic physical or mental impairments, or both, in a variety of institutional and noninstitutional settings, including the home, with the goal of promoting the optimum level of physical, social, and psychological functioning of the individuals.

(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.

(j) "Screening" means a preliminary determination of need for long-term care services and, on the basis of such determination, the making of an appropriate referral for a client assessment in accordance with subsection (3) of this section or referral to another community resource to assist clients 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 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' needs, to analyze alternative forms of care and the payment sources for such care, and to assist in the selection of long-term care programs and services that meet clients' needs most cost-efficiently.

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

(I) Nursing facilities;

(II) Home- and community-based services for the elderly, the blind, and the disabled;

(III) Alternative care facilities;

(IV) to (VI) (Deleted by amendment, L. 2008, p. 437, § 1, effective August 5, 2008.)

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

(VIII) Home- and community-based services for persons living with acquired immune deficiency syndrome (AIDS).

(c) Private paying clients 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 long-term care. The instrument shall be used as part of the comprehensive and uniform client assessment process to be established in accordance

with paragraph (a) of this subsection (3) and shall serve the following functions:

- (I) To obtain information on each client's status in the following areas:
 - (A) Activities of daily living and instrumental activities of daily living;
 - (B) Physical health;
 - (C) Cognitive and emotional well-being;
 - (D) Social interaction and current support resources;
 - (II) To assess each client's physical environment in terms of meeting the client's needs;
 - (III) To obtain information on each client's payment sources, including obtaining financial eligibility information for publicly funded long-term care programs;
 - (IV) To disclose the need for more intensive needs assessments in areas such as nutrition, adult protection, dementia, and mental health;
 - (V) To prioritize a client's need for care using criteria established by the state department for specific publicly funded long-term care programs;
 - (VI) To serve as the functional assessment for the determinations of medical necessity.
- (e) On and after July 1, 1991, no publicly funded client shall be placed in a long-term care program unless such placement is in accordance with rules adopted by the state board in implementing this section.
- (4) Repealed.

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

- (a) A study of a single entry point system in accordance with former section 26-4.5-404, C.R.S., has been completed;
 - (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 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 over time and will provide better information on the unmet service needs of clients; and
 - (d) The implementation of a statewide single entry point system is a comprehensive undertaking and would be more conducive to a phased-in approach.
- (2) The general assembly further finds, determines, and declares that it is appropriate to develop and implement, through four phases, a single entry point system for the state and, therefore, enacts sections 26-4-522 to 26-4-525, which were relocated to sections 25.5-6-106 and 25.5-6-107, respectively, in the 2006 recodification of this title, to provide for such development and implementation.

25.5-6-106. Single entry point system - authorization - phases for implementation - services provided. (1) **Authorization.** The state board is hereby authorized to adopt rules providing for the establishment of a single entry point system that consists of single entry point agencies throughout the state for the purpose of enabling persons eighteen years of age or older in need of long-term care to access appropriate long-term care services.

(2) **Single entry point agencies - service programs - functions.** (a) A single entry point agency shall be an agency in a local community through which any person eighteen years of age or older who is in need of long-term care can access needed long-term care services. A single entry point agency may be a private, nonprofit organization, a county agency, including a county department of social services, a county nursing service, an area agency on aging, or a multicounty agency. Persons in need of specialized assistance such as services for developmental disabilities or mental illness may be referred by a single entry point agency to programs under the department of human services.

(b) The agency may serve private paying clients on a fee-for-service basis and shall serve clients of publicly funded long-term care programs, including, but not limited to, the following:

- (I) Nursing facility care;
- (II) Home- and community-based services for the elderly, blind, and disabled;
- (III) Home- and community-based services for persons living with acquired immune deficiency syndrome;
- (IV) Long-term home health care, including services provided by a PACE organization providing a program of all-inclusive care for the elderly pursuant to section 25.5-5-412;
- (V) Home care allowance;
- (VI) Alternative care facilities;
- (VII) Adult foster care;
- (VIII) Certain in-home services available pursuant to the federal "Older Americans Act of 1965", as amended; and
- (IX) Home- and community-based services for persons with brain injury.

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

- (I) Providing information;
- (II) Screening and referral services;
- (III) Assessing clients' needs in accordance with section 25.5-6-104;
- (IV) Developing plans of care for clients;
- (V) Determining payment sources available to clients for long-term care services;
- (VI) Authorizing the provision of certain long-term care services, as designated by the state department;

(VII) Determining eligibility for certain long-term care programs, as designated by the state department;

(VIII) Delivering case management services as an administrative function;

(IX) Targeting outreach efforts to those most at risk of institutionalization;

(IX.5) Informing eligible persons about the benefits of participating in the program of all-inclusive care for the elderly provided by a PACE organization pursuant to section 25.5-5-412 as an alternative to enrollment in a managed care organization, an organization contracted with the state department pursuant to part 4 of article 5 of this title, or other risk-bearing entity.

(X) Identifying resource gaps and coordinating resource development;

(XI) Recovering overpayment of benefits in accordance with rules adopted by the state board;

(XII) Maintaining fiscal accountability; and

(XIII) Rendering state certified services, as provided by state board rules, as a qualified and state certified agency.

(3) **State certification of a single entry point agency - quality assurance standards.** (a) Upon selection of a single entry point agency, the state department shall contract with an agency for five years but shall recertify the agency annually based on an evaluation procedure provided for in paragraph (b) of this subsection (3).

(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 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, timely responses, managing programs in one consolidated unit, on-site visits to clients, community coordination and outreach, and client monitoring; a determination as to whether targeted populations are being identified and served; and an evaluation concerning financial accountability.

(c) The state department shall monitor each single entry point agency in the state for compliance with quality assurance standards adopted by the state and may provide for the implementation of sanctions at any time for noncompliance. In addition, each county department may enter into cooperative agreements or contracts with the single entry point agencies to assure quality performance by the single entry point agency serving such county.

(d) Ongoing reimbursement to single entry points shall be contingent upon compliance with quality assurance standards.

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

(a) Federal financial participation moneys available for case management for home- and community-based services pursuant to this article, and for administration of medical assistance programs, pursuant to Title XIX of the federal "Social Security Act", as amended;

(b) The state's share or contribution for specific long-term care programs in accordance with or pursuant to sections 26-1-122 and 26-2-114, C.R.S.;

(c) County contributions, as follows:

(I) The total for the fiscal year beginning July 1, 1990, and for each fiscal year thereafter, which totals shall serve as the base for determining the contribution required in subparagraph (II) of this paragraph (c), of the following: The counties' five percent contribution for home care allowance and adult foster care services as required by section 26-1-122, C.R.S.

(II) The amount contributed from each county in accordance with subparagraph (I) of this paragraph (c) after making an adjustment based on the percentage of an increase or decrease per fiscal year in the service costs for clients of such county. However, in no case shall a county be required under this subparagraph (II) to contribute more than a five percent increase in said service costs.

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

25.5-6-108. Legislative declaration - advisory committee - long-term care - report - repeal. (Repealed)

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 pursuant to paragraph (c) of this subsection (1), the state department shall contract for one or more studies of the population of recipients receiving services under the home- and community-based waivers authorized pursuant to this article. 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.

(b) If a study conducted pursuant to this subsection (1) concludes that a program of home- and community-based services would result in cost savings, the state department shall seek any necessary federal authorization to implement the program. If federal authorization to implement the program is obtained, the state department shall request, through the state budget process, that the program be implemented. The state department shall report to the joint budget committee annually concerning the amount of any savings realized from the program.

(c) The state department is authorized to seek and accept gifts, grants, or donations from private and public sources for the purposes of this subsection (1); except that the state department may not accept a gift, grant, or donation that is subject to conditions that are inconsistent with this subsection (1) or any other law of the state. The state department shall transmit all private and public moneys received through gifts, grants, or donations to the state treasurer, who shall credit the same to the department of health care policy and financing cash fund created in section 25.5-1-109.

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

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

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

(III) The amount of savings associated with providing services at an alternative care facility;

(IV) Recommendations for utilization controls or program controls for a program to provide services at an alternative care facility;

(V) The experiences of the program of all-inclusive care for the elderly, created pursuant to section 25.5-5-412, with tiered rates for alternative care facilities, including cost savings or cost avoidance;

(VI) Other states' experiences with tiered rates for alternative care facilities, including cost savings or cost avoidance; and

(VII) Recommendations for maintaining or improving quality of care.

(b) The study conducted pursuant to this subsection (2) shall be completed by January 1, 2012, and, if federal approval is obtained prior to final figure-setting for the fiscal year commencing July 1, 2012, the state department shall submit a request through the budget process for implementation of the approved changes for that fiscal year.

25.5-6-109. Community long-term care - coordinated care pilot program -

federal authorization - rules - repeal. (Repealed)

25.5-6-110. Private-public partnership education and information program concerning long-term care insurance authorized. (1) The general assembly hereby declares that:

- (a) A large number of Coloradans are in need of long-term health care;
- (b) The cost of long-term care, especially nursing home care, is significant;
- (c) Many persons in need of long-term care are ineligible for state medical assistance due to countable resources. When faced with the need for long-term care, such persons expend such resources to pay for nursing home care.

- (d) A person's resources may cover only a relatively short period of care, often resulting in rendering such person impoverished, and after which time the person must rely on state medical assistance;

- (e) Expenditures for long-term care represent a significant portion of the state's medical assistance budget;

- (f) Unless Colorado implements new methods for financing long-term care, which methods include participation by the private sector, the cost to the state for long-term care will increase astronomically; and

- (g) It is therefore appropriate to enact legislation that allows the state department, upon a determination by the executive director of the state department that it is feasible, to design and implement a private-public partnership for financing long-term care in this state.

(2) The state department shall cooperate with the division of insurance in the department of regulatory agencies in a private-public partnership for financing long-term care in this state through the availability of long-term care insurance policies that result in a reduction of total dependency on the medical assistance program to finance such care. It is the general assembly's intent that such partnership shall be designed to encourage individuals to purchase long-term care insurance, which, with respect to middle to higher income individuals, will have the result of eliminating or delaying the individual's need for medical assistance.

(3) Under the partnership described in subsection (2) of this section, the division of insurance shall implement statutory changes to article 19 of title 10, C.R.S., concerning long-term care policies that the general assembly hereby declares are necessary to accomplish the purpose of the partnership described in this section. In addition, the state department is encouraged to implement a public education-awareness program based on recommendations from an advisory committee that the executive director of the state department is hereby authorized to establish.

(4) The state department is authorized to seek and accept funds, grants, or donations from any private entity for implementing the public education-awareness

program. In addition, if necessary, the state department may assess a fee in connection with conducting any public education-awareness training program or seminar. Any such fee collected shall be transmitted to the state treasurer, who shall credit the same to the long-term care insurance fund, which fund is hereby created. The moneys in the fund shall be subject to annual appropriation by the general assembly for the sole purpose of public education-awareness training programs and seminars.

(5) In addition to administering the public education-awareness program under the partnership, the state department shall seek a federal waiver from the requirement of section 13612 of the federal "Omnibus Budget Reconciliation Act of 1993" (OBRA), Public Law 103-66, that prevents the state department from granting medical assistance applicants a full or partial resource exemption in determining eligibility for medical assistance and an exemption from estate recovery requirements.

(6) The state department, if funds are available, shall contract with a public or private entity to conduct an evaluation of the public education-awareness program on or before December 1, 2000.

(7) With respect to a policyholder who has allowed his or her private long-term care insurance policy to lapse, if the person is found to be eligible for the medical assistance program, the state department is authorized to pay the premium for a reinstated policy pursuant to section 10-19-107 (2), C.R.S., if the state department finds that to do so is feasible and cost-efficient.

25.5-6-111. Pilot program for coordinated care for people with a disability - fund - repeal.

(1) to (3) Repealed.

(4) (a) There is hereby created in the state treasury the coordinated care for people with disabilities fund, referred to in this section as the "fund", that shall consist of moneys transferred to the fund pursuant to section 25.5-5-308 (8), any moneys that may be appropriated to the fund by the general assembly, and any gifts, grants, or donations received by the state department for the purpose of implementing this section. The moneys in the fund shall be subject to annual appropriation by the general assembly for the direct and indirect costs associated with the implementation of the pilot program. Any moneys in the fund not expended for the purpose of this section may be invested by the state treasurer as provided by law. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund. Any unexpended and unencumbered moneys remaining in the fund as of July 1, 2013, shall be transferred to the disability investigational and pilot support fund created in section 24-30-2205.5, C.R.S. If this section is repealed, prior to its repeal, all unexpended and unencumbered moneys remaining in the fund shall be transferred to the general fund.

(b) This subsection (4) is repealed, effective July 1, 2014.

(5) to (7) Repealed.

25.5-6-112. Plan of financial operation - purpose - approval - financial audits - rules - repeal. (Repealed)

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

(I) The state demographer office in the department of local affairs estimates that between 2005 and 2015, the portion of Colorado's population that is over sixty-five years of age will increase by more than twenty-three percent;

(II) This drastic increase in the population that is over sixty-five years of age is driven by the aging "baby boomer" generation and will result in a parallel increase in a demand for community long-term care services;

(III) Older adults, persons with disabilities, and their families need quality health care coverage and choice and flexibility in accessing community long-term care services that support their independence and ability to live in the least restrictive environment;

(IV) Research has shown that older adults suffer from higher rates of depression, have a higher risk of suicide, and have an increased misuse of prescription and illicit drugs, making the need for behavioral health care services essential to long-term care services;

(V) Coloradans deserve to have access to the proper level of health care;

(VI) The state needs a long-term care delivery system that addresses the needs of older adults, persons with disabilities, and their families, and health care coverage and coordination should not be fragmented or difficult to access; instead, it should be integrated to meet the needs of older adults, persons with disabilities, and their families;

(VII) A community long-term care system should be integrated, person-centered, and provide maximum service delivery and make efficient use of available public funds; and

(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 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 and efficient use of limited resources.

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

(a) "Dually eligible person" means a person who is eligible for assistance or

benefits under both medicaid and medicare.

(b) "Health home" means a provider or group of providers that operate in coordination with a team of health care professionals that shall include primary care providers selected by an eligible individual with chronic conditions to provide health home services, as the term is defined in section 2703 of the federal "Patient Protection and Affordable Care Act", 42 U.S.C. sec. 1396w-4.

(3) (a) In determining the structure of health homes for chronic conditions for purposes of the federal "Patient Protection and Affordable Care Act", 42 U.S.C. sec. 1396w-4, and state plan amendments to the medicaid program, the state department shall include, to the extent permitted under federal law, provisions allowing providers of long-term care services and supports to participate as health homes or as part of a health home that provides:

- (I) Comprehensive care management;
- (II) Care coordination and health promotion;
- (III) Comprehensive transitional care;
- (IV) Patient and family support;
- (V) Referral to community and social support services; and
- (VI) The use of health information technology to link services, as is feasible and appropriate.

(b) The health home may consist of a multi-disciplinary team, including primary care management providers, behavioral health care providers, case managers, and providers of long-term care services and supports, including but not limited to single entry point agencies, nursing homes, alternative care facilities, day programs for the elderly, home care agencies, community mental health centers, hospice and palliative care centers, and community centered boards.

(4) To the extent provided under federal law, in integrating dually eligible persons, persons with chronic conditions, or persons needing long-term care services and supports in an organization with which the state department contracts pursuant to part 4 of article 5 of this title, the state department shall permit providers of long-term services and supports to contract as health homes or to provide some or all of the services provided by the organization contracted with the state department, which services may include, but need not be limited to, navigation of primary, specialty, or long-term care supports.

(5) Dually eligible clients 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.

25.5-6-114. Alternative care facilities - reimbursement programs - legislative declaration - report - repeal. (1) (a) The general assembly hereby finds and declares that:

- (I) The number of Coloradans needing long-term care is increasing;
 - (II) State general fund expenditures for long-term care already represent a significant portion of the state's medical assistance budget;
 - (III) Many persons in need of long-term care are often unaware that they may be able to receive long-term care services in a home-like environment, at a lower cost to the medicaid program;
 - (IV) Studies have been conducted informing the state that an enhanced reimbursement methodology is necessary for the establishment of a strong continuum of care for long-term care;
 - (V) Other alternatives to nursing home care should be developed and implemented; and
 - (VI) Unless Colorado implements new methods for financing long-term care, the cost to the state for long-term care services will continue to rise precipitously.
- (b) Therefore, the general assembly finds that it is appropriate to establish a program to provide greater financial incentives to alternative care facilities that are able to meet the needs of medicaid clients at a lower cost to the medicaid program.
- (2) In order to decrease the number of costly readmissions to nursing facilities, the state department may create an enhanced reimbursement program in which an alternative care facility receives a temporary increase in the medicaid per diem reimbursement rate for a medicaid client discharged from a nursing facility to an alternative care facility. The state department shall develop the criteria for participation in the enhanced reimbursement program.
- (3) In order to address the needs of medicaid clients who are at risk of nursing home placement, the state department may also create a program, informed by prior studies, that may include, but need not be limited to, tiered-rate, acuity, and enhanced reimbursements for alternative care facilities and enhanced alternative care services. Any program created by the state department pursuant to this subsection (3) shall be budget-neutral or shall produce cost savings to the state department.
- (4) As part of its annual reporting requirement, the state department shall submit a written report to the joint budget committee of the general assembly, the health and human services committee of the senate, or any successor committee, and the health and environment committee of the house of representatives, or any successor committee, concerning the design, implementation, and outcome of any program created pursuant to subsection (2) or (3) of this section.
- (5) This section is repealed, effective July 1, 2015.

PART 2

NURSING FACILITIES

25.5-6-201. Special definitions relating to nursing facility reimbursement. As used in this part 2, unless the context otherwise requires:

(1) "Acquisition cost" means the actual allowable cost to the owners of a capital-related asset or any improvement thereto as determined in accordance with generally accepted accounting principles.

(2) "Actual cost" or "cost" means the audited cost of providing services.

(3) "Administration and general services costs" means costs in the following categories:

(a) Advertising, recruitment, and public relations, to the extent that such costs are necessary, reasonable, and patient-related;

(b) Travel and training of facility staff, unless the travel includes residents of the facility or the training is for the facility staff described in paragraph (a) of subsection (15) of this section; and

(c) All other costs that are not direct or indirect health care services, raw food costs, or capital-related assets.

(4) "Appraised value" means the determination by a qualified appraiser who is a member of an institute of real estate appraisers, or its equivalent, of the depreciated cost of replacement of a capital-related asset to its current owner. The depreciated replacement appraisal shall be based on the "Boeckh Commercial Underwriter's Valuation System for Nursing Homes". The depreciated cost of replacement appraisal shall be redetermined every four years by new appraisals of the nursing facilities. The new appraisals shall be based upon rules promulgated by the state board.

(5) "Array of facility providers" means a listing in order from lowest per diem cost facility to highest for that category of costs or rates, as may be applicable, of all medicaid-participating nursing facility providers in the state.

(6) (a) "Base value" means:

(I) For the fiscal year 1986-87 and every fourth year thereafter, the appraised value of a capital-related asset;

(II) For each year in which an appraisal is not done pursuant to subparagraph (I) of this paragraph (a), the most recent appraisal together with fifty percent of any increase or decrease each year since the last appraisal, as reflected in the index.

(b) For the fiscal year 1985-86, the base value shall not exceed twenty-five thousand dollars per licensed bed at any participating facility, and, for each succeeding fiscal year, the base value shall not exceed the previous year's limitation adjusted by any increase or decrease in the index.

(c) An improvement to a capital-related asset, which is an addition to that asset, as defined by rules adopted by the state board, shall increase the base value by the acquisition cost of the improvement.

(7) "Capital-related asset" means the land, buildings, and fixed equipment of a participating facility.

(8) "Case-mix" means a relative score or weight assigned for a given group of residents based upon their levels of resources, consumption, and needs.

(9) "Case-mix adjusted direct health care services costs" means those costs comprising the compensation, salaries, bonuses, workers' compensation, employer-contributed taxes, and other employment benefits attributable to a nursing facility provider's direct care nursing staff whether employed directly or as contract employees, including but not limited to registered nurses, licensed practical nurses, and nurses' aides.

(10) "Case-mix index" means a numeric score assigned to each nursing facility resident based upon a resident's physical and mental condition that reflects the amount of relative resources required to provide care to that resident.

(11) "Case-mix neutral" means the direct health care costs of all facilities adjusted to a common case-mix.

(12) "Case-mix reimbursement" means a payment system that reimburses each facility according to the resource consumption in treating its case-mix of medicaid residents, which case-mix may include such factors as the age, health status, resource utilization, and diagnoses of the facility's medicaid residents as further specified in this section.

(13) "Class I facility" means a private for-profit or not-for-profit nursing facility provider or a facility provider operated by the state of Colorado, a county, a city and county, or special district that provides general skilled nursing facility care to residents who require twenty-four-hour nursing care and services due to their ages, infirmity, or health care conditions, including residents who are behaviorally challenged by virtue of severe mental illness or dementia.

(14) "Direct health care services costs" means those costs subject to case-mix adjusted direct health care services costs.

(15) "Direct or indirect health care services costs" means the costs incurred for patient support services, including the following:

(a) Salaries, payroll taxes, workers' compensation payments, training, and other employee benefits for registered nurses, licensed practical nurses, aides, medical records librarians, social workers, and activity personnel;

(b) Nonprescription drugs ordered by a physician;

(c) Consultant fees for nursing, medical records, patient activities, social workers, pharmacies, physicians, and therapies;

(d) Purchases, rentals, and costs incurred to operate, maintain, or repair health care equipment;

(e) Supplies for nurses, medical records personnel, social workers, activity personnel, and therapy personnel;

(f) Medical director fees;

(g) Therapies and other medically related services, including the following:

(I) Utilization review;

- (II) Dental care, when required by federal law;
 - (III) Audiology;
 - (IV) Psychology;
 - (V) Physical therapy;
 - (VI) Recreational therapy;
 - (VII) Occupational therapy; and
 - (VIII) Speech therapy;
- (h) Other patient support services determined and defined by the state board pursuant to rule;
- (i) Raw food costs that do not include the costs of equipment, staff, or other costs associated with meal preparation;
 - (j) Malpractice insurance;
 - (k) Depreciation and interest for major health care equipment, such as equipment purchased for the sole purpose of providing care to facility residents; and
 - (l) Photocopying related to health care purposes such as medical records of patients.
- (16) "Facility population distribution" means the number of Colorado nursing facility residents who are classified into each resource utilization group as of a specific point in time.
- (17) "Fair rental allowance" means the product obtained by multiplying the base value of a capital-related asset by the rental rate.
- (18) "Improvement" means the addition to a capital-related asset of land, buildings, or fixed equipment.
- (19) "Index" means the RSMeans construction systems cost index or an equivalent index that is based upon a survey of prices of common building materials and wage rates for nursing home construction.
- (20) "Index maximization" means classifying a resident who could be assigned to more than one category to the category with the highest case-mix index.
- (21) "Median per diem cost" means the average daily cost of care and services per patient for the nursing facility provider that represents the middle of all of the arrayed facilities participating as providers or as the number of arrayed facilities may dictate, the mean of the two middle providers.
- (22) "Minimum data set" means a set of screening, clinical, and functional status elements that are used in the assessment of a nursing facility provider's residents under the federal medicare and medicaid programs.
- (23) "Normalization ratio" means the statewide average case-mix index divided by the facility's cost report period case-mix index.
- (24) "Normalized" means multiplying the nursing facility provider's per diem case-mix adjusted direct health care services cost by its case-mix index normalization ratio for the purpose of making the per diem cost comparable among facilities based upon

a common case-mix in order to determine the maximum allowable reimbursement limitation.

(25) "Nursing facility provider" means a facility provider that meets the state nursing home licensing standards established pursuant to section 25-1.5-103 (1) (a), C.R.S., and is maintained primarily for the care and treatment of inpatients under the direction of a physician.

(26) "Nursing salary ratios" means the relative difference in hourly wages of registered nurses, licensed practical nurses, and nurses' aides.

(27) "Nursing weights" means numeric scores assigned to each category of the resource utilization groups that measure the relative amount of resources required to provide nursing care to a nursing facility provider's residents.

(28) "Occupancy-imputed days" means the use of a predetermined number for patient days rather than actual patients days in computing per diem cost.

(29) "Per diem cost" means the daily cost of care and services per patient for a nursing facility provider.

(30) "Per diem rate" means the daily dollar amount of reimbursement that the state department shall pay a nursing facility provider per patient.

(31) "Provider fee" means a licensing fee, assessment, or other mandatory payment that is related to health care items or services as specified under 42 CFR 433.55.

(32) "Raw food" means the products and substances, including but not limited to nutritional supplements, that are consumed by residents.

(33) "Rental rate" means the average annualized composite rate for United States treasury bonds issued for periods of ten years and longer plus two percent. The rental rate shall not exceed ten and three-quarters percent nor fall below eight and one-quarter percent.

(34) "Resource utilization groups" means the system for grouping a nursing facility's residents according to their clinical and functional statuses as identified from data supplied by the facility's minimum data set as published by the United States department of health and human services.

(35) "Statewide average per diem rate" means the average daily dollar amount of the per patient payments to all medicaid-participating facility providers in the state.

(36) "Supplemental medicaid payment" means a lump sum payment that is made in addition to a provider's per diem rate. A supplemental medicaid payment is calculated on an annual basis using historical data and paid as a fixed monthly amount with no retroactive adjustment.

25.5-6-202. Providers - nursing facility provider reimbursement - rules - repeal. (1) (a) (I) Subject to available appropriations, for the purpose of reimbursing a medicaid-certified class I nursing facility provider a per diem rate for the cost of direct

and indirect health care services and raw food, the state department shall establish an annually readjusted schedule to pay each nursing facility provider the actual amount of the costs. The payment shall not exceed one hundred twenty-five percent of the median cost of direct and indirect health care services and raw food as determined by an array of all facility providers; except that, for state veteran nursing homes, the payment shall not exceed one hundred thirty percent of the median cost.

(II) For the fiscal year commencing July 1, 2009, and for each fiscal year thereafter, any increase in the direct and indirect health care services and raw food costs shall not exceed eight percent per year. The calculation of the eight percent per year limitation for rates effective on July 1, 2009, shall be based on the direct and indirect health care services and raw food costs in the as-filed facility's cost reports up to and including June 30, 2009. For the purposes of calculating the eight-percent limitation for rates effective after July 1, 2009, the limitation shall be determined and indexed from the direct and indirect health care services and raw food costs as reported and audited for the rates effective July 1, 2009.

(b) In computing per diem cost, each nursing facility provider shall annually submit cost reports, and actual days of care shall be counted, not occupancy-imputed days of care. In addition, in determining the median cost, the cost of direct health care shall be case-mix neutral. The cost reports used by the state department to establish the per diem cost shall be those filed with the state department during the period ending December 31 of the prior year following implementation of this subsection (1) and for each succeeding year. The state department shall redetermine the median per diem cost based upon the most recent cost reports filed during the period ending December 31 of the prior year.

(2) The state department shall further adjust and, subject to available appropriations, pay the per diem rate to the nursing facility provider for the cost of direct health care services based upon the acuity or case-mix of the nursing facility provider residents in order to provide for the resource utilization of its residents. The state department shall determine this adjustment in accordance with each resident's status as identified and reported by the nursing facility provider on its federal medicare and medicaid minimum data set assessment. The state department shall establish a case-mix index for each nursing facility provider according to the resource utilization groups system, using only nursing weights. The state department shall calculate nursing weights based upon standard nursing time studies and weighted by facility population distribution and Colorado-specific nursing salary ratios. The state department shall determine an average case-mix index for each nursing facility provider's medicaid residents on a quarterly basis.

(3) (a) Subject to available appropriations, for the purpose of reimbursing a medicaid-certified class I nursing facility provider a per diem rate for the cost of its administrative and general services, the state department shall establish an annually readjusted schedule to pay each nursing facility provider a reasonable price for the costs,

which reasonable price shall be a percentage of the median per diem cost of administrative and general services as determined by an array of all nursing facility providers. For facilities of sixty licensed beds or fewer, the reasonable price shall be one hundred ten percent of the median per diem cost for all class I facilities. For facilities of sixty-one licensed beds and more, the reasonable price shall be one hundred five percent of the median per diem cost for all class I facilities.

(b) In computing per diem cost, each nursing facility provider shall annually submit cost reports to the state department, and actual days of care shall be counted, not occupancy-imputed days of care. The cost reports used to establish this median per diem cost shall be those filed during the period ending December 31 of the prior year following implementation of this subsection (3), and, for each succeeding fourth year, the state department shall redetermine the median per diem cost based upon the most recent cost reports filed during the period ending December 31 of the prior year.

(c) (I) For fiscal years commencing on or after July 1, 2008, through the fiscal year commencing July 1, 2014, the state department shall compare a nursing facility provider's administrative and general services per diem rate as determined under this subsection (3) to the nursing facility provider's administrative and general services per diem rate as of June 30, 2008, and the state department shall pay the nursing facility provider the higher per diem amount for each of the fiscal years.

(II) For fiscal years commencing on or after July 1, 2009, through the fiscal year commencing July 1, 2014, if a reallocation of management costs between the administrative and general costs described in paragraph (a) of this subsection (3) and the direct and indirect health care costs described in subsection (1) of this section causes a nursing facility provider's administrative and general costs to exceed the reasonable price established by the state department pursuant to paragraph (a) of this subsection (3), pursuant to rules adopted by the state board, a nursing facility provider may receive a higher per diem payment for administrative and general services than provided for in paragraph (a) of this subsection (3).

(III) This paragraph (c) is repealed, effective July 1, 2015.

(4) In addition to the reimbursement components paid pursuant to subsections (1) to (3) of this section, a per diem rate constituting a fair rental allowance for capital-related assets shall be paid to each nursing facility provider as a rental rate based upon the nursing facility's appraised value.

(5) Subject to available moneys and the priority of the uses of the provider fees as established in section 25.5-6-203 (2) (b), in addition to the reimbursement rate components paid pursuant to subsections (1) to (4) of this section, the state department shall make a supplemental medicaid payment based upon performance to those nursing facility providers that provide services that result in better care and higher quality of life for their residents. This amount shall be determined by the state department based upon performance measures established in rules adopted by the state board in the domains of

quality of life, quality of care, and facility management. The payment shall be computed annually as of July 1, 2009, and each July 1 thereafter, and shall not be less than twenty-five hundredths of one percent of the statewide average per diem rate for the combined rate components determined pursuant to subsections (1) to (4) of this section. During each state fiscal year, the state department may discontinue the supplemental medicaid payment established pursuant to this subsection (5) to any nursing facility provider that fails to comply with the established performance measures during the state fiscal year, and the state department may initiate the supplemental medicaid payment established pursuant to this subsection (5) to any provider who comes into compliance with the established performance measures during the state fiscal year.

(6) Subject to available moneys and the priority of the uses of the provider fees as established in section 25.5-6-203 (2) (b), in addition to the reimbursement rate components pursuant to subsections (1) to (5) of this section, the state department shall make a supplemental medicaid payment to nursing facility providers who have residents who have moderately to very severe mental health conditions, cognitive dementia, or acquired brain injury as follows:

(a) A supplemental medicaid payment shall be made to nursing facility providers that serve residents who have severe mental health conditions that are classified at a level II by the medicaid program's preadmission screening and resident review assessment tool. The state department shall compute this payment annually as of July 1, 2009, and each July 1 thereafter, and it shall be not less than two percent of the statewide average per diem rate for the combined rate components determined pursuant to subsections (1) to (4) of this section.

(b) A supplemental medicaid payment shall be made to nursing facility providers who serve residents with severe cognitive dementia or acquired brain injury. The state department shall calculate the payment based upon the resident's cognitive assessment established in rules adopted by the state board. The state department shall compute this payment annually as of July 1, 2009, and each July 1 thereafter, and it shall be not less than one percent of the statewide average per diem rate for the combined rate components determined under subsections (1) to (4) of this section.

(7) Subject to available moneys and the priority of the uses of the provider fees as established in section 25.5-6-203 (2) (b), in addition to the reimbursement rate components paid pursuant to subsections (1) to (6) of this section, the state department shall pay a nursing facility provider a supplemental medicaid payment for care and services rendered to medicaid residents to offset payment of the provider fee assessed under the provisions of section 25.5-6-203. The state department shall compute this payment annually, as of July 1, 2009, and each July 1 thereafter.

(8) (Deleted by amendment, L. 2009, (SB 09-263), ch. 203, p. 912, § 2, effective May 1, 2009.)

(9) (a) The per diem amount paid for direct and indirect health care services and

administrative and general services costs shall include an allowance for inflation in the costs for each category using a nationally recognized service that includes the federal government's forecasts for the prospective medicare reimbursement rates recommended to the United States congress. Amounts contained in cost reports used to determine the per diem amount paid for each category shall be adjusted by the percentage change in this allowance measured from the midpoint of the reporting period of each cost report to the midpoint of the payment-setting period.

(b) (I) Except for changes in the number of patient days, the general fund share of the aggregate statewide average of the per diem rate net of patient payment pursuant to subsections (1) to (4) of this section shall be limited to an annual increase of three percent. The state's share of the reimbursement rate components pursuant to subsections (1) to (4) of this section may be funded through the provider fee assessed pursuant to the provisions of section 25.5-6-203 and any associated federal funds. Any provider fee used as the state's share and all federal funds shall be excluded from the calculation of the general fund limitation on the annual increase. For the fiscal year commencing July 1, 2009, and for each fiscal year thereafter, the general fund share of the aggregate statewide average per diem rate net of patient payment pursuant to subsections (1) to (4) of this section shall be calculated using the rates that were effective on July 1 of that fiscal year.

(II) If the aggregate statewide average per diem rate net of patient payment pursuant to subsections (1) to (4) of this section exceeds the general fund share, the amount of the average statewide per diem rate that exceeds the general fund share shall be paid as a supplemental medicaid payment using the provider fee established under section 25.5-6-203. Subject to the priority of the uses of the provider fee established under section 25.5-6-203 (2) (b), if the provider fee is insufficient to fully fund the supplemental medicaid payment, the supplemental medicaid payment shall be reduced to all providers proportionately.

(III) and (IV) Repealed.

(V) (A) Notwithstanding any other provision of law, commencing July 1, 2012, through June 30, 2013, the general fund portion of the per diem rate pursuant to subsections (1) to (4) of this section shall be reduced by one and one-half percent. The state department may, but is not required to, increase the supplemental medicaid payment pursuant to subparagraph (II) of this paragraph (b) due to this reduction; except that the provider fee shall not exceed the amount specified in section 25.5-6-203 (1) (a) (II).

(B) This subparagraph (V) is repealed, effective July 1, 2014.

(VI) Notwithstanding any other provision of law, for the fiscal year commencing July 1, 2013, and each fiscal year thereafter, the general fund portion of the per diem rate pursuant to subsections (1) to (4) of this section shall be reduced by one and one-half percent. The state department may, but is not required to, increase the supplemental medicaid payment pursuant to subparagraph (II) of this paragraph (b) due to this reduction; except that the provider fee shall not exceed the amount specified in section

25.5-6-203 (1) (a) (II).

(b.3) (I) For the fiscal year commencing July 1, 2009, and for each fiscal year thereafter, if the provider fee established under section 25.5-6-203 is insufficient to fully fund the supplemental medicaid payments established under subsections (5) to (7) of this section, subject to the priority of the uses of the provider fee established pursuant to section 25.5-6-203 (2) (b), the state department may suspend or reduce the supplemental medicaid payment subject to the uses of the provider fee established under section 25.5-6-203.

(II) If it is determined by the state department that the case-mix reimbursement includes a factor for nursing facility providers who serve residents with severe cognitive dementia or acquired brain injury, the state department may eliminate the supplemental medicaid payment to those providers who serve residents with severe cognitive dementia or acquired brain injury.

(b.5) Notwithstanding any other provision of law or any federal law that temporarily increases the federal matching participation rate for any fiscal year, payments to nursing facility providers from the general fund share of the aggregate statewide average of the per diem rate shall be calculated based on a fifty-percent federal match.

(b.7) Repealed.

(c) (I) The general assembly finds that the historical growth in nursing facility provider rates has significantly exceeded the rate of inflation. These increases have been caused in part by the inclusion of medicare costs in medicaid cost reports. The state of Colorado has an interest in limiting these exceptional increases in medicaid nursing facility provider rates by removing medicare part B direct costs from the medicaid nursing facility provider rates and by imposing a ceiling on the medicare part A ancillary costs that are included in calculating medicaid nursing facility rates.

(II) For all rates effective on or after July 1, 1997, for each class I nursing facility provider, only such costs as are reasonable, necessary, and patient-related may be reported for reimbursement purposes. Nursing facility providers may include the level of medicare part A ancillary costs that was included and allowed in the facility's last medicaid cost report filed prior to July 1, 1997. Any subsequent increase in this amount shall be limited to either the increase in the facility's allowable medicare part A ancillary costs or the percentage increase in the cost of medical care reported in the United States department of labor bureau of labor statistics consumer price index for the same time period, whichever is lower. Part B direct costs for medicare shall be excluded from the allowable reimbursement for facilities.

(III) The specific methodology for calculating the limitations and cost-reporting requirements described in this paragraph (c) shall be established by rules promulgated by the state board.

(d) The reimbursement rate components pursuant to subsections (5) to (7) of this section shall be funded entirely through the provider fee assessed pursuant to the

provisions of section 25.5-6-203 and any associated federal funds. No general fund moneys shall be used to pay for the reimbursement rate components established pursuant to subsections (5) to (7) of this section.

(10) The state board shall promulgate rules pursuant to the "State Administrative Procedure Act", article 4 of title 24, C.R.S., to implement this section, including establishing uniform accounting, reporting, and payment procedures consistent with this section, to determine a nursing facility provider's costs and payments to the provider.

(11) (Deleted by amendment, L. 2009, (SB 09-263), ch. 203, p. 912, § 2, effective May 1, 2009.)

25.5-6-203. Nursing facilities - provider fees - federal waiver - fund created - rules. (1) (a) (I) Beginning with the fiscal year commencing July 1, 2008, and each fiscal year thereafter, the state department shall charge and collect provider fees on health care items or services provided by nursing facility providers for the purpose of obtaining federal financial participation under the state's medical assistance program as described in articles 4 to 6 of this title. As specified by the priority of the uses of the provider fee in paragraph (b) of subsection (2) of this section, the provider fees shall be used to sustain or increase reimbursement for providing medical care under the state's medical assistance program for nursing facility providers.

(II) For the fiscal years commencing July 1, 2009, and July 1, 2010, the provider fee shall not exceed seven dollars and fifty cents per nonmedicare-resident day. For the fiscal year commencing July 1, 2011, and each fiscal year thereafter, the provider fee shall not exceed twelve dollars per nonmedicare-resident day plus inflation based on the national skilled nursing facility market basket index as determined by the secretary of the department of health and human services pursuant to 42 U.S.C. sec. 1395yy (e) (5) or any successor index.

(III) In calculating the amount of the provider fee portion of the supplemental medicaid payments established under section 25.5-6-202 (5), the state department may include an additional amount of up to five percent of the provider fee portion of said supplemental medicaid payments to initiate the payment to any provider who complies with the established performance measures during the state fiscal year.

(b) The provider fees shall be charged on a nonmedicare-resident day basis and shall be based upon the aggregate gross or net revenue, as prescribed by the state department, of all nursing facility providers subject to the provider fee. The state department may exempt revenue categories from the gross or net revenue calculation and the collection of the provider fee from nursing facility providers, as authorized by federal law.

(c) In accordance with the redistributive method set forth in 42 CFR 433.68 (e) (1) and (e) (2), the state department shall seek a waiver from the broad-based provider fees

requirement or the uniform provider fees requirement, or both, to exclude nursing facility providers from the provider fee. The state department shall exempt the following nursing facility providers to obtain federal approval and minimize the financial impact on nursing facility providers:

(I) A facility operated as a continuing care retirement community that provides a continuum of services by one operational entity providing independent living services, assisted living services, and skilled nursing care on a single, contiguous campus. Assisted living services include an assisted living residence as defined in section 25-27-102, C.R.S., or that provides assisted living services on-site, twenty-four hours per day, seven days per week.

(II) A skilled nursing facility owned and operated by the state;

(III) A nursing facility that is a distinct part of a facility that is licensed as a general acute care hospital; and

(IV) A facility that has forty-five or fewer licensed beds.

(d) The state department may lower the amount of the provider fee charged to certain nursing facility providers to meet the requirements of 42 CFR 433.68 (e) and to obtain federal approval.

(e) The imposition and collection of a provider fee shall be prohibited without the federal government's approval of a state medicaid plan amendment authorizing federal financial participation for the provider fees. The state department may alter the method prescribed in this section to the extent necessary to meet the federal requirements and to obtain federal approval.

(f) If the provider fee required by this subsection (1) is not approved by the federal government, notwithstanding any other provision of this section, the state department shall not implement the assessment or collection of the provider fee from nursing facility providers.

(g) The state department shall establish a schedule to assess and collect the provider fee on a monthly basis. The state board shall establish rules so that provider fee payments from a nursing facility provider and the state department's supplemental medicaid payments to the nursing facility are due as nearly simultaneously as feasible; except that the state department's supplemental medicaid payments to the nursing facility shall be due no more than fifteen days after the provider fee payment is received from the nursing facility. The state department shall require each nursing facility provider to report annually its total number of days of care provided to nonmedicare residents.

(h) The state department shall not assess or collect the provider fee until state medicaid plan amendments adopting the medicaid reimbursement system for the state's class I nursing facility providers, pursuant to section 25.5-6-202, including the waiver with respect to the provider fees pursuant to this section, have been approved by the federal government.

(i) The state board shall promulgate any rules pursuant to the "State

Administrative Procedure Act", article 4 of title 24, C.R.S., necessary for the administration and implementation of this section.

(j) A nursing facility provider shall not include any amount of the provider fee as a separate line item in its billing statements.

(2) (a) All provider fees collected pursuant to this section by the state department shall be transmitted to the state treasurer, who shall credit the same to the medicaid nursing facility cash fund, which fund is hereby created and referred to in this section as the "fund".

(b) (I) All moneys in the fund shall be subject to federal matching as authorized under federal law and subject to annual appropriation by the general assembly for the purpose of paying the administrative costs of implementing section 25.5-6-202 and this section and to pay the supplemental medicaid payments to offset payment of the provider fee established under section 25.5-6-202 (7).

(II) Following the payment of the amounts described in subparagraph (I) of this paragraph (b), the moneys remaining in the fund shall be subject to federal matching as authorized under federal law and subject to annual appropriation by the general assembly for the purpose of paying the supplemental medicaid payments for acuity or case-mix of residents established under section 25.5-6-202 (2).

(III) (A) Except as provided in sub-subparagraph (B) of this subparagraph (III), after the payment of the amounts described in subparagraphs (I) and (II) of this paragraph (b), the moneys remaining in the fund shall be subject to federal matching as authorized under federal law and subject to annual appropriation by the general assembly for the purpose of paying the supplemental medicaid payments for higher quality performance established under section 25.5-6-202 (5).

(B) Notwithstanding any other provision of this paragraph (b), the supplemental medicaid payments established pursuant to section 25.5-6-202 (5) shall not be less than ten percent of the supplemental medicaid payments established under section 25.5-6-202 (7) in the prior state fiscal year.

(IV) Following the payment of the amounts described in subparagraphs (I) to (III) of this paragraph (b), the moneys remaining in the fund shall be subject to federal matching as authorized under federal law and subject to annual appropriation by the general assembly for the purpose of paying the supplemental medicaid payments for residents who have moderately to very severe mental health conditions, cognitive dementia, or acquired brain injury established under section 25.5-6-202 (6).

(V) Following the payment of the amounts described in subparagraphs (I) to (IV) of this paragraph (b), the moneys remaining in the fund shall be subject to federal matching as authorized under federal law and subject to annual appropriation by the general assembly for the purpose of paying the supplemental medicaid payments for the amount by which the average statewide per diem rate exceeds the general fund share established under section 25.5-6-202 (9) (b) (II).

(VI) Any moneys in the fund not expended for the purposes specified in this section may be invested by the state treasurer as provided by law. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund. Any unexpended and unencumbered moneys remaining in the fund at the end of any fiscal year shall remain in the fund and shall not be credited or transferred to the general fund or any other fund but may be appropriated by the general assembly to pay nursing facility providers in future fiscal years.

25.5-6-204. Providers - reimbursement - intermediate care facility for individuals with intellectual disabilities - reimbursement - maximum allowable. (1) (a) For the purpose of making payments to intermediate care facilities for individuals with intellectual disabilities, the state department shall establish a price schedule to be readjusted every twelve months, that shall reimburse, subject to available appropriations, each provider, as nearly as possible, for its actual or reasonable cost of services rendered, whichever is less, its case-mix adjusted direct health care services costs as defined in section 25.5-6-201 (9), and a fair rental allowance for capital-related assets as defined in section 25.5-6-201 (7). The state board shall adopt rules, including uniform accounting or reporting procedures, in order to determine the actual or reasonable cost of services and case-mix adjusted direct health care services costs and the reimbursement therefor. The provisions of this paragraph (a) shall not apply to state-operated intermediate care facilities for individuals with intellectual disabilities.

(b) State-operated intermediate care facilities for individuals with intellectual disabilities shall be reimbursed based on the actual costs of administration, property, including capital-related assets, and room and board, and the actual costs of providing health care services, and such costs shall be projected by such facilities and submitted to the state department by July 1 of each year for the ensuing twelve-month period. Reimbursement to state-operated intermediate care facilities for individuals with intellectual disabilities shall be adjusted retrospectively at the close of each twelve-month period. The state board shall adopt rules to be effective by June 30, 1988, implementing the provisions of this paragraph (b). In the implementation of such rules, the state department shall ensure, by the establishment of classes of facilities, that the reimbursement to private, nonprofit, or proprietary state-operated intermediate care facilities for individuals with intellectual disabilities or the developmentally disabled, as defined in section 27-10.5-102 (11), C.R.S., is not adversely impacted.

Editor's note: This version of paragraph (b) is effective until March 1, 2014.

(b) State-operated intermediate care facilities for individuals with intellectual disabilities shall be reimbursed based on the actual costs of administration, property,

including capital-related assets, and room and board, and the actual costs of providing health care services, and such costs shall be projected by such facilities and submitted to the state department by July 1 of each year for the ensuing twelve-month period. Reimbursement to state-operated intermediate care facilities for individuals with intellectual disabilities shall be adjusted retrospectively at the close of each twelve-month period. The state board shall adopt rules to be effective by June 30, 1988, implementing the provisions of this paragraph (b). In the implementation of such rules, the state department shall ensure, by the establishment of classes of facilities, that the reimbursement to private, nonprofit, or proprietary state-operated intermediate care facilities for individuals with intellectual disabilities, as defined in section 25.5-10-202, is not adversely impacted.

Editor's note: This version of paragraph (b) is effective March 1, 2014.

(c) (I) Beginning in fiscal year 2013-14, and for each fiscal year thereafter, the state department is authorized to charge both privately owned intermediate care facilities for individuals with intellectual disabilities and state-operated intermediate care facilities for individuals with intellectual disabilities a service fee for the purposes of maintaining the quality and continuity of services provided by intermediate care facilities for individuals with intellectual disabilities. The service fee charged by the state department pursuant to this paragraph (c) will be assessed pursuant to rules adopted by the state board but must not exceed five percent of the total costs incurred by all intermediate care facilities for the fiscal year in which the service fee is charged. The state board shall adopt rules consistent with federal law in order to implement the provisions of this paragraph (c).

(II) The moneys collected in each fiscal year pursuant to subparagraph (I) of this paragraph (c) shall be transmitted by the state department to the state treasurer, who shall credit the same to the service fee fund, which fund is hereby created and referred to in this paragraph (c) as the "fund". The moneys in the fund shall be subject to annual appropriation by the general assembly to the state department to be used toward the state match for the federal financial participation to reimburse intermediate care facilities for individuals with intellectual disabilities pursuant to this section. Any unexpended and unencumbered moneys remaining in the fund at the end of any fiscal year shall remain in the fund and not be credited or transferred to the general fund or any other fund.

(2) (a) In addition to the actual or reasonable costs and the reimbursement therefor, the state department shall, subject to available appropriations, include an allowance equal to the change in the national bureau of labor statistics consumer price index from the preceding year to compensate for fluctuating costs. This amount shall be determined every twelve months when the statewide average cost is determined by adjusting for inflation. The provider's allowable cost shall be multiplied by the change in

the consumer price index measured from the midpoint of the provider's cost report period to the midpoint of the provider's rate period. This allowance is applied to all costs, including case-mix adjusted direct health care services costs as defined in section 25.5-6-201 (9), less interest, up to the reasonable cost established and will be allowed to proprietary, nonprofit, and tax-supported homes; except that the allowance shall not be applied to the costs of state-operated intermediate facilities for individuals with intellectual disabilities.

(b) (I) The state board shall adopt rules to:

(A) Determine and pay to privately owned intermediate care facilities for individuals with intellectual disabilities a reasonable share of the amount by which the reasonable costs of the categories of administration, property, and room and board, excluding food costs, exceed the actual cost in these categories only. The reasonable share shall be defined as twenty-five percent of the amount in the categories for each facility, not to exceed twelve percent of the reasonable cost.

(B) (Deleted by amendment, L. 2008, p. 1783, § 5, effective July 1, 2008.)

(II) (Deleted by amendment, L. 2008, p. 1783, § 5, effective July 1, 2008.)

(c) to (e) (Deleted by amendment, L. 2008, p. 1783, § 5, effective July 1, 2008.)

(3) to (5) (Deleted by amendment, L. 2008, p. 1783, § 5, effective July 1, 2008.)

(6) and (7) Repealed.

25.5-6-205. Collection of penalties assessed against nursing facilities - creation of cash fund. (1) (a) The state department shall assess, enforce, and collect any civil penalties that are recommended by the department of public health and environment pursuant to the authority granted under section 25-1-107.5, C.R.S.

(b) Prior to the denial of medicaid payments or the assessment of a civil money penalty against a nursing facility, the nursing facility shall be offered by the state department an opportunity for a hearing in accordance with the provisions of section 24-4-105, C.R.S. Enforcement and collection of the denial of medicaid payments or civil money penalty shall occur following the decision reached at such hearing.

(2) In conjunction with the authority granted under subsection (1) of this section, the state board shall promulgate rules that:

(a) Provide any nursing facility assessed a civil penalty the opportunity to appeal such assessment;

(b) Govern the procedures for such appeals, including the right of a nursing facility to thirty days' notice prior to the collection of any civil money penalty; and

(c) Are otherwise necessary to implement this section.

(3) (a) Any civil penalties collected by the state department pursuant to this section shall be transmitted to the state treasurer, who shall credit the same to the nursing home penalty cash fund, which fund is hereby created.

(b) (I) The moneys in the fund are subject to annual appropriation by the general assembly to the state department for the purposes set forth in section 25-1-107.5, C.R.S.

(II) Such moneys shall be used in the manner prescribed in section 25-1-107.5, C.R.S., and the rules promulgated thereunder.

(c) All interest derived from the deposit and investment of moneys in the fund shall be credited to the fund.

(d) At the end of any fiscal year, all unexpended and unencumbered moneys remaining in the fund shall remain therein and shall not be credited or transferred to the general fund or any other fund.

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

(2) (a) The basic minimum amount payable pursuant to subsection (1) of this section for personal needs to any recipient admitted to a nursing facility or intermediate care facility for individuals with intellectual disabilities is fifty dollars monthly.

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

(I) A medical assistance recipient 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 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.

(3) (a) All personal needs funds shall be held in trust by the nursing facility or intermediate care facility for individuals with intellectual disabilities, or its designated trustee, separate and apart from any other funds of the facility. The facility shall deposit any personal needs funds of a resident in an amount of fifty or more dollars in an interest-bearing checking account or accounts or savings account or any combination thereof

established to protect and separate the personal needs funds of the patients. Any interest earned on a resident's personal needs funds shall be credited to such account or accounts. In the event residents' personal needs funds are maintained in a pooled account, separate accountings shall be made for each resident's share of the pooled account. Any personal needs funds of a resident in an amount less than fifty dollars shall be maintained in a non-interest-bearing account, an interest-bearing account, or a petty cash fund.

(b) At all times, the principal and all income derived from said principal in the patient personal needs trust fund shall remain the property of the participating patients, and the facility or its designated trustee is bound by all of the duties imposed by law upon fiduciaries in the handling of such fund. Those duties include but are not limited to providing notice to a resident when the resident's personal needs account accumulates two hundred dollars less than the federal supplemental security income resource limit for one person.

(c) The facility or its designated trustee shall post a surety bond in an amount to assure the security of all personal needs funds deposited in the patient personal needs trust fund or shall otherwise demonstrate to the satisfaction of the state department that the security of residents' personal needs funds is assured.

(d) Within sixty days after a resident's death, the facility shall transfer the resident's personal needs funds and a final accounting of the funds to the person responsible for settling the resident's estate or, if there is none, to the resident's heirs in accordance with the provisions of title 15, C.R.S. Within fifteen days after receiving the funds, the executor, administrator, or other appropriate representative of the resident's estate shall provide written notice to the state department regarding the receipt of the funds. Upon receipt of the notice, the state department may bring an action to recover the funds pursuant to the provisions of this article and articles 4 and 5 of this title.

(4) The state department shall establish rules concerning the establishment of a patient personal needs trust fund and procedures for the maintenance of a system of accounting for expenditures of each patient's personal needs funds. The facility shall use an accounting system that assures a complete and separate accounting of residents' personal needs funds based on generally accepted accounting principles and that precludes the commingling of a resident's personal needs funds with the facility's funds or the funds of any other person other than the personal needs funds of another resident. These rules shall provide that the nursing facility or intermediate care facility for individuals with intellectual disabilities shall maintain complete records of all receipts and expenditures involving the patient personal needs trust fund, that all expenditures shall be approved by the patient, legal custodian, guardian, or conservator prior to an expenditure, and that each patient or such patient's legal custodian, guardian, or conservator shall be given at least a quarterly accounting of the receipts and expenditures of such funds. In addition, the rules shall require that the person who maintains the patient personal needs trust fund for the facility and who is responsible for the deposit of moneys

into such trust fund shall deposit any personal needs funds received from a patient or from the state department no later than sixty days after the receipt of such moneys.

(5) All patient personal needs trust funds shall be subject to audit by the state department. A record of a patient's personal needs trust fund shall be kept by the facility for a period of three years from the date of the patient's discharge from the facility or until such records have been audited by the state department, whichever occurs later.

(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 recoverable by the state on behalf of the recipient in the same manner and following the same procedures as specified in section 25.5-4-301 (2) for an overpayment to a provider.

(7) Nothing in this section shall prevent a nursing facility or intermediate care facility for individuals with intellectual disabilities patient from excluding himself or herself from participation in the patient personal needs trust fund.

(8) (a) It is unlawful for any person to knowingly fail to deposit personal needs funds received from a patient or from the state department for a patient's personal needs into the patients' personal needs trust fund within sixty days after the receipt of such moneys or to knowingly apply, spend, commit, pledge, or otherwise use a patient personal needs trust fund, or any other moneys paid by a patient or the state department for patient personal needs, for any purpose other than the personal needs of the patient to purchase necessary clothing, incidentals, or other items of personal needs that are not reimbursed by any federal or state program. Deposit or use of personal needs funds, including the use of a petty cash fund for personal needs purposes, is not a violation of this section if such deposit or use is in substantial compliance with applicable rules of the state department. Sums later ordered repaid to the patients' personal needs trust fund as a result of an audit adjustment related to simple accounting errors such as data entry errors, mathematical errors, or posting errors or a dispute related to a proration of patient payment is not a violation of this section.

(b) Any person who knowingly violates any of the provisions of this subsection (8) by failing to deposit personal needs funds within sixty days after the receipt of such moneys commits the crime of unlawful retention of patient personal needs funds. Any person who violates any of the provisions of this subsection (8) by applying, spending, committing, pledging, or otherwise using a patient personal needs trust fund for any purpose other than the purposes permitted by this subsection (8) commits the crime of unlawful use of a patient personal needs trust fund.

(c) Unlawful retention of patient personal needs funds is a class 3 misdemeanor. When a person commits unlawful retention of patient personal needs funds twice or more within a period of six months without having been placed in jeopardy for the prior offense

or offenses, unlawful retention of patient personal needs funds is a class 1 misdemeanor.

(d) Unlawful use of a patient personal needs trust fund is:

(I) A class 2 misdemeanor, if the amount involved is less than five hundred dollars;

(II) A class 1 misdemeanor, if the amount involved is five hundred dollars or more but less than one thousand dollars;

(III) A class 4 felony, if the amount involved is one thousand dollars or more but less than twenty thousand dollars;

(IV) A class 3 felony, if the amount involved is twenty thousand dollars or more.

(e) Any person who is convicted of violating this subsection (8) may not own or operate a nursing facility that receives medical assistance pursuant to this article or article 4 or 5 of this title. For the purposes of this paragraph (e), "convicted" means the entry of a plea of guilty, including a plea of guilty entered pursuant to a deferred sentence under section 18-1.3-102, C.R.S., the entry of a plea of no contest accepted by the court, or the entry of a verdict of guilty by a judge or jury.

25.5-6-207. Class I nursing facility reimbursement rates - study - report - repeal. (Repealed)

PART 3

HOME- AND COMMUNITY-BASED SERVICES FOR THE ELDERLY, BLIND, AND DISABLED

25.5-6-301. Short title. This part 3 shall be known and may be cited as the "Home- and Community-based Services for the Elderly, Blind, and Disabled Act".

25.5-6-302. Legislative declaration. The general assembly hereby finds and declares that it is the purpose of this part 3 to provide, under a federal waiver of statutory requirements, for an array of home- and community-based services to eligible elderly, blind, and disabled individuals as an alternative to nursing facility placement.

25.5-6-303. Definitions. As used in this part 3 and part 5 of this article, unless the context otherwise requires:

(1) "Adult day care facility" means a facility which meets all applicable state and federal requirements and is certified by the state to provide adult day care services to

eligible persons.

(2) "Adult day care services" means health and social services provided on a less than twenty-four-hour basis to eligible persons in state-certified adult day care facilities.

(3) "Alternative care facility" means a residential facility which provides alternative care services and protective oversight to eligible persons, which meets applicable state and federal requirements, and which is state-certified.

(4) "Alternative care services" means a package of personal care and homemaker services provided in a state-certified alternative care facility.

(5) (a) "Case management agency" means agencies providing services on and before July 1, 1995, for home- and community-based programs for the elderly, blind, and disabled and for persons living with AIDS shall be terminated July 1, 1995, and case management functions shall thereafter be performed in accordance with this article.

(b) "Case management agency", for counties participating in the single entry point system pursuant to this article before July 1, 1995, and for all counties on and after said date, means a public or private, nonprofit or for profit agency that meets all applicable state and federal requirements and is certified by the state department to provide case management functions reimbursable under this article and articles 4 and 5 of this title, within a geographic area of the state consisting of one or more counties. Such functions shall be provided by the agency under a contract executed with the state department or other state designated agency. The state department shall establish procedures for the designation, certification, and decertification of case management agencies and requirements for performance and staffing of the agencies. Such procedures and requirements shall be set forth in rules promulgated by the state board or shall be included in the contracts executed by the state department.

(6) "Case management services" means functions performed by a case management agency, including: The assessment of a client's needs, the development and implementation of a case plan for the client, the coordination and monitoring of service delivery, the direct delivery of services as provided by parts 3 to 12 of this article or by rules adopted by the state board, the evaluation of service effectiveness, and the reassessment of the client's needs. Case management services shall be reimbursed as an administrative expense.

(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, his family or guardian and physician, and other providers of care.

(8) "Electronic monitoring provider" means an entity that meets applicable state, federal, and local requirements and is certified to provide electronic monitoring services.

(9) "Electronic monitoring services" means electronic equipment or adaptations that are related to an eligible person's physical impairment and enable the person to remain at home.

(10) "Homemaker agency" means any agency that meets applicable state and federal requirements and is state-certified to provide homemaker services.

(11) "Homemaker services" means general household activities that are provided by state-certified agencies to maintain a healthy and safe home environment for eligible persons.

(12) "Home modification provider" means an entity that meets applicable state, federal, and local requirements and is certified to provide home modification services.

(13) "Home modification services" means home installations or adaptations that are related to the eligible person's physical impairment and enable the person to remain at home.

(14) "Medications administration" means the administration or monitoring of medications provided in a manner consistent with part 3 of article 1.5 of title 25, C.R.S., under the authority and direction of the state department, as part of the "alternative care services", as defined in subsection (4) of this section, as provided in an "alternative care facility", as defined in subsection (3) of this section.

(15) "Nonmedical transportation provider" means an entity that meets applicable state and federal requirements and is certified to provide nonmedical transportation services.

(16) "Nonmedical transportation services" means transportation of eligible persons to services such as, but not limited to, adult day care services, which enable the person to remain at home.

(17) "Personal care agency" means any agency that meets state and federal requirements and is state-certified to provide personal care services.

(18) "Personal care services" means services to meet an eligible person's physical requirements and functional needs, when such services do not require the supervision of a nurse.

(19) "Respite care provider" means a facility or agency that meets all applicable state and federal requirements and is state-certified to provide respite care services.

(20) "Respite care services" means services of a short-term nature provided to a client, 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, including room and board, maintenance, personal care, and other related services.

(21) "Transition coordination service agency" means an agency that is certified by the state department, as specified in rule by the state board, and provides independent living core services as defined in section 26-8.1-102 (3), C.R.S., and community transition services.

25.5-6-304. Administration. The provisions of this part 3 shall be administered

by the state department.

25.5-6-305. Provision of services for elderly, blind, and disabled persons. The provision of the services set forth in this part 3 shall be subject to the availability of federal matching medicaid funds, pursuant to Title XIX of the federal "Social Security Act", as amended, for payment of the costs for administration and costs for the provision of such services.

25.5-6-306. Eligible groups. (1) Home- and community-based services under this part 3 shall be offered only to persons:

- (a) Who are elderly, blind, or physically disabled; and
- (b) Who are in need of the level of care available in a nursing home; and
- (c) Who are categorically eligible for medical assistance, or whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, and whose resources do not exceed the limit established for individuals receiving a mandatory minimum state supplementation of supplemental security income benefits or, in the case of a person who is married, do not exceed the amount authorized in section 25.5-6-101.

(2) A long-term-care eligible person receiving home- and community-based services shall remain eligible for the services specified in sections 25.5-5-102, 25.5-5-103, 25.5-5-202, and 25.5-5-203, as applicable.

25.5-6-307. Services for the elderly, blind, and disabled. (1) Subject to the provisions of this part 3, home- and community-based services for the elderly, blind, and disabled shall include only the following services:

- (a) Adult day care;
- (b) Alternative care services;
- (c) Electronic monitoring services;
- (d) Home modification services;
- (e) Homemaker services;
- (f) Nonmedical transportation services;
- (g) Personal care services;
- (h) Respite care services;
- (i) Community transition services not to exceed two thousand dollars per eligible person, unless otherwise authorized by the state department, which shall be administered by a transition coordination service agency;
- (j) Services provided under the consumer-directed care service model, part 11 of

this article.

(2) All providers of home- and community-based services for the elderly, blind, and disabled may be separately certified to provide other services, if otherwise qualified.

(3) A case management agency may be certified to provide the services described in subsection (1) of this section, if otherwise qualified as a provider under the state medical assistance program.

(4) (a) The case management agency, in coordination with the eligible person, the person's family or guardian, and the person's physician, shall include in each case plan a process by which the eligible person may receive necessary care, which may include respite care, if the eligible person's family or service provider is unavailable due to an emergency situation or to unforeseen circumstances. The eligible person and the person's family or guardian shall be duly informed by the case management agency of these alternative care provisions at the time the case plan is initiated.

(b) The requirements of this subsection (4) shall not apply if the eligible person is residing in an alternative care facility.

25.5-6-308. Cost of services. Home- and community-based services for the elderly, blind, and disabled shall meet aggregate federal waiver budget neutrality requirements.

25.5-6-309. Special provisions - post-eligibility treatment of income. Persons who receive services under this part 3 shall pay to the state department, or designated agent or provider, all income remaining after application of federally allowed maintenance and medical deductions or shall pay the cost of home- and community-based services rendered, whichever is less.

25.5-6-310. Special provisions - personal care services provided by a family. (1) A member of an eligible person's family, other than the person's spouse, may be employed to provide personal care services to such person.

(2) The maximum reimbursement for the services provided by a member of the person's family per year for each client shall not exceed the equivalent of four hundred forty-four service units per year for a member of the eligible person's family.

25.5-6-311. Duties of state department. (1) The state department shall:

(a) Seek and utilize any available federal, state, or private funds which are available for carrying out the purposes of this part 3, including but not limited to medicaid

funds, pursuant to Title XIX of the federal "Social Security Act", as amended;

(b) Provide a system for reimbursement for services provided pursuant to this part 3, which system shall encourage cost containment.

25.5-6-312. Gifts - grants. The state department, acting for and on behalf of the state, may receive and accept title to any grant or gift from any source, including the federal government, and all grants, grants-in-aid, and gifts shall be deposited with the state treasurer, who shall credit the same to the general fund, and such moneys shall be appropriated to the state department to carry out the purposes of this article and articles 4 and 5 of this title.

25.5-6-313. Rules - federal authorization. (1) Pursuant to article 4 of title 24, C.R.S., the state board shall adopt rules for the administration of this part 3.

(1.5) The rules adopted by the state board pursuant to subsection (1) of this section shall include the following provisions concerning adult day care facilities:

- (a) A definition of a restricted environment and a restrictive egress alert device;
- (b) Parameters governing how the restrictive egress alert device shall be used and tested and the staff roles regarding the use and oversight of the device; and
- (c) Parameters governing a restricted environment, including but not limited to staffing and training requirements; appropriateness of placement; assessment; participant's rights; records and reporting requirements; building requirements including grounds and fire safety; restrictive egress alert systems and devices; fencing or other enclosures; and the application process to offer a restricted environment.

(2) The state department is authorized to seek any necessary federal authorization to implement the provisions of this part 3.

PART 4

HOME- AND COMMUNITY-BASED SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

25.5-6-401. Short title. This part 4 shall be known and may be cited as the "Home- and Community-based Services for Persons with Developmental Disabilities Act".

25.5-6-402. Legislative declaration. (1) The general assembly hereby finds and

declares that it is the purpose of this part 4 to provide services for persons with developmental disabilities which would foster the following goals:

(a) To maintain eligible persons in the most appropriate settings possible and to minimize admissions to institutions;

(b) To recognize the unique services requirements of persons with developmental disabilities;

(c) To provide optimum accessibility to various important social, habilitative, remedial, residential, and health services that are available to assist in maintaining eligible persons in the least restrictive settings;

(d) To provide eligible persons who have the capacity to remain outside an institutional setting access to appropriate social, habilitative, remedial, residential, and health services, without which institutionalization would be necessary;

(e) To provide the most efficient and effective use of funds in the delivery of these social, habilitative, remedial, residential, and health services to eligible persons;

(f) To coordinate, integrate, and link these social, habilitative, remedial, residential, and health services into existing community-based service delivery systems for persons with developmental disabilities, to avoid unnecessary and expensive duplication of services;

(g) To allow the state substantial flexibility in organizing and administering the delivery of social, habilitative, remedial, residential, and health services to eligible citizens.

(2) The general assembly intends that the state department and the department of human services shall cooperate to the maximum extent possible in designing, implementing, and administering the programs authorized under this part 4.

(3) Nothing in this part 4 shall be construed to disqualify persons from receiving any benefits to which they would otherwise be eligible under parts 1 and 2 of article 5 of this title, or under Title XIX of the federal "Social Security Act", as amended, by reason of being designated as a person with developmental disabilities.

25.5-6-403. Definitions. As used in this part 4, unless the context otherwise requires:

(1) "Developmentally disabled person" means a person with a developmental disability as defined in section 27-10.5-102, C.R.S.

Editor's note: This version of subsection (1) is effective until March 1, 2014.

(1) "Developmentally disabled person" means a person with an intellectual and developmental disability as defined in section 25.5-10-202.

Editor's note: This version of subsection (1) is effective March 1, 2014.

(2) (a) "Eligible person" means a person with developmental disabilities:

(I) Who meets the definition of categorically needy as defined in section 25.5-4-103 (4);

(II) Who is in need of the level of care available in an intermediate care facility for individuals with intellectual disabilities;

(III) Whose gross income does not exceed three hundred percent of the current federal supplemental security income benefits level or other applicable standard provided in federal regulations construing the federal "Social Security Act", as amended, and whose resources do not exceed the limit established for individuals receiving a mandatory minimum state supplementation of supplemental security income benefits or, in the case of a person who is married, do not exceed the amount authorized in section 25.5-6-101; and

(IV) For whom it is determined that provision of such services is necessary to avoid placement in an intermediate care facility for individuals with intellectual disabilities.

(b) The amount of parental income and resources that shall be attributable to a child's gross income for purposes of eligibility under paragraph (a) of this subsection (2) shall be set forth in rules promulgated by the state board of human services created in section 26-1-107, C.R.S.

(3) "In-home services" means those services described in section 27-10.5-406, C.R.S., provided to support individuals living with their family.

Editor's note: This version of subsection (3) is effective until March 1, 2014.

(3) "In-home services" means those services described in section 25.5-10-205 provided to support persons living with their family.

Editor's note: This version of subsection (3) is effective March 1, 2014.

(4) "Plan of care" means a coordinated plan of care for provision of services in other than a nursing facility or institutional setting, developed and managed, subject to review and approval pursuant to section 25.5-6-404, by a community centered board for persons with developmental disabilities. This plan of care shall fully identify the services to be provided to eligible persons. Prior to the provision of those services, a physician may be required to review an assessment document to insure that it adequately describes the medical needs of the eligible person.

(5) (a) "Services for persons with developmental disabilities" means those services:

Editor's note: This version of the introductory portion to paragraph (a) is effective

until March 1, 2014.

(5) (a) "Services for persons with intellectual and developmental disabilities" means those services:

Editor's note: This version of the introductory portion to paragraph (a) is effective March 1, 2014.

(I) Approved for reimbursement by the federal government; and

(II) Necessary to prevent a person, eligible for services under subsection (2) of this section, from being subjected to placement in an intermediate care facility for individuals with intellectual disabilities.

(b) "Services for the developmentally disabled" includes, but is not limited to: Social, habilitative, remedial, residential, health services, and services provided under the consumer-directed care service model, part 11 of this article, which shall include the selection, from a list of qualified entities, of an organization of the eligible person's choice to provide financial management services for the eligible person.

Editor's note: This version of paragraph (b) is effective until March 1, 2014.

(b) "Services for persons with intellectual and developmental disabilities" includes, but is not limited to, social, habilitative, remedial, residential, health services, and services provided under the consumer-directed care service model, part 11 of this article, which shall include the selection, from a list of qualified entities, of an organization of the eligible person's choice to provide financial management services for the eligible person.

Editor's note: This version of paragraph (b) is effective March 1, 2014.

25.5-6-404. Duties of the department of health care policy and financing and the department of human services. (1) The state department and the department of human services shall provide a system of reimbursement for services provided pursuant to this part 4 that encourages the most cost-effective provision of services.

(2) The state department and the department of human services shall, subject to appropriation, utilize any available federal, state, local, or private funds, including but not limited to, medicaid funds available under Title XIX of the federal "Social Security Act", as amended, such as medicaid home- and community-based waivers, to carry out the

purposes of this part 4.

(3) The state department may contract with the department of human services to certify agencies providing services under this part 4 as eligible medicaid providers, to adopt fiscal and administrative procedures, to review plans of care, to set rates, and to make and implement recommendations regarding the scope, duration, and content of programs and the eligibility of persons for specific services provided pursuant to this part 4, and to fulfill any other responsibilities necessary to implement this part 4 that are consistent with the single state agency designation set out in section 25.5-4-104.

(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 rules may include, but shall not be limited to, determination of the level of care requirements for long-term care, patient payment requirements, clients' rights, medicaid eligibility, and appeal rights associated with these requirements.

(5) The state board of human services, created in section 26-1-107, C.R.S., shall promulgate such rules as are necessary to implement the provisions of this part 4 and to fulfill the responsibilities and duties set out in article 10.5 of title 27, C.R.S. Such rules shall be promulgated pursuant to section 24-4-103, C.R.S.

(6) In the event that a direct conflict arises between the rules of the state department promulgated pursuant to subsection (4) of this section and the rules of the department of human services promulgated pursuant to subsection (5) of this section, regarding implementation of this part 4, the rules of the state department shall control.

25.5-6-405. Relationship to other programs. The provisions of part 3 of this article are separate and distinct from the provisions of this part 4. Therefore, the definitions and restrictions embodied in part 3 of this article shall not apply to services and programs provided pursuant to this part 4.

25.5-6-406. Appropriations. To carry out duties and obligations pursuant to this part 4 and for the administration and provision of services to eligible persons, all medicaid funds appropriated pursuant to Title XIX of the federal "Social Security Act", as amended, for the provision of care for persons with developmental disabilities and all other funds otherwise appropriated by the general assembly as additional sources of program funding shall be available for the placement of eligible individuals either in intermediate care facilities for individuals with intellectual disabilities or alternatives to such placements.

25.5-6-407. Gifts - grants. The state department and the department of human services, acting on behalf of the state, may receive and accept title to gifts or grants from any source, including the federal government. Both departments shall deposit all grants, grants-in-aid, and gifts with the state treasurer, who shall credit them to the general fund. These moneys shall remain available for appropriation to either department to carry out the purposes of this part 4.

25.5-6-408. Eligibility - fees. (1) Subject to the availability of federal financial participation, services shall be provided to eligible persons pursuant to this part 4.

(2) Any eligible person who accepts and receives services pursuant to this part 4 shall pay to the state department, or to an agent designated by the state department, an amount determined pursuant to federal regulations construing the federal "Social Security Act", as amended, concerning the application of patient income to the cost of services.

25.5-6-409. Services for persons with intellectual and developmental disabilities. (1) A program to provide home- and community-based services to persons with developmental disabilities who are in need of the level of care available in an intermediate care facility for individuals with intellectual disabilities is hereby established pursuant to the federal "Social Security Act", as amended. This program shall provide for the social, habilitative, remedial, residential, health, and other needs of persons with developmental disabilities to avoid placement in an intermediate care facility for individuals with intellectual disabilities.

Editor's note: This version of subsection (1) is effective until March 1, 2014.

(1) A program to provide home- and community-based services to persons with intellectual and developmental disabilities who are in need of the level of care available in an intermediate care facility for individuals with intellectual disabilities is hereby established pursuant to the federal "Social Security Act", as amended. This program shall provide for the social, habilitative, remedial, residential, health, and other needs of persons with intellectual and developmental disabilities to avoid placement in an intermediate care facility for individuals with intellectual disabilities.

Editor's note: This version of subsection (1) is effective March 1, 2014.

(2) Services for persons with developmental disabilities provided through this program shall be delivered under the provisions of a statewide services plan, in the form of home- and community-based services waivers or model waivers, developed by the state

department and the department of human services and approved by the federal centers for medicare and medicaid services, or any successor agency. This plan shall include the specific services to be offered, a plan for the delivery of such services through community centered boards or other service agencies approved pursuant to article 10.5 of title 27, C.R.S., utilizing where appropriate the provision of in-home services, the expected costs of such services, the expected benefits of providing those services, and the administrative provisions which shall govern the implementation of the plan. The plan shall provide for all necessary safeguards to ensure the health and welfare of any eligible persons. The average per capita expenditure for services under this plan shall not exceed the average per capita expenditure the department of human services or the state department would have made for services otherwise available without this plan.

(3) The plan shall utilize existing community-based services programs to the maximum extent possible and shall coordinate all available forms of assistance for the eligible person.

(4) Any services for the developmentally disabled provided through this program shall be set forth in a plan of care developed and managed by a community centered board and subject to review and approval pursuant to section 25.5-6-404. The plan of care shall:

Editor's note: This version of the introductory portion to subsection (4) is effective until March 1, 2014.

(4) Any services for persons with intellectual and developmental disabilities provided through this program shall be set forth in a plan of care developed and managed by a community-centered board and subject to review and approval pursuant to section 25.5-6-404. The plan of care shall:

Editor's note: This version of the introductory portion to subsection (4) is effective March 1, 2014.

(a) Be based on the particular services needs of the eligible person;

(b) Describe the services necessary to avoid institutionalization; and

(c) (I) Include a process by which the person who is receiving services may receive necessary care for medical purposes, which may include respite care, if the person's service provider is unavailable due to an emergency situation or to unforeseen circumstances. The person who is receiving services and the person's family or guardian shall be duly informed by the community centered board of these alternative care provisions at the time the plan of care is initiated.

(II) Nothing in this paragraph (c) requires a community centered board to provide services set forth in a plan of care that the community centered board is not otherwise required to provide to the person receiving services, only that the plan of care include a

contingency for such services.

25.5-6-410. Qualification for federal funding. Nothing in this part 4 shall prevent the state department or the department of human services from complying with federal requirements in order for the state of Colorado to qualify for federal funds under Title XIX of the federal "Social Security Act", as amended.

25.5-6-411. Personal needs trust fund required. All personal needs funds shall be held in trust by a residential facility authorized to provide services pursuant to this part 4, or its 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. At all times, the principal and all income derived from said principal in the personal needs trust fund shall remain the property of the participating clients, and the facility or its designated trustee is bound by all of the duties imposed by law upon fiduciaries in the handling of such fund including accounting for all expenditures from the fund.

PART 5

HOME- AND COMMUNITY-BASED SERVICES FOR PERSONS WITH HEALTH COMPLEXES RELATED TO ACQUIRED IMMUNE DEFICIENCY SYNDROME

25.5-6-501. Short title. This part 5 shall be known and may be cited as the "Home- and Community-based Services for Persons with Health Complexes Related to Acquired Immune Deficiency Syndrome Act".

25.5-6-502. Definitions. In addition to the definitions in section 25.5-6-303, as used in this part 5, unless the context otherwise requires:

- (1) "AIDS" means acquired immune deficiency syndrome.
- (2) "Continuum of long-term care" shall include all the services listed in section 25.5-6-505 and may include brief inpatient stays in a hospital or a nursing facility.
- (3) "HIV" means the human immunodeficiency virus.
- (4) "HIV/AIDS" means:
 - (a) A symptomatic HIV infection, as defined by the centers for disease control of the United States public health service; or

- (b) AIDS.
- (5) "Long-term-care eligible person" means a person who is determined to be:
 - (a) Eligible to receive services under sections 25.5-5-102, 25.5-5-103, 25.5-5-202, and 25.5-5-203; and
 - (b) In need of the level of care available in a nursing facility or in need of the level of care available in a hospital.

25.5-6-503. Administration. The provisions of this part 5 shall be administered by the state department.

25.5-6-504. Program established - financial eligibility. (1) In recognition of the social and economic benefits accruing from the maintenance of persons with HIV/AIDS in their own homes, the general assembly hereby finds and declares that a program shall be implemented by the state department to provide the services set forth in section 25.5-6-505 to those persons with HIV/AIDS whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, whose resources do not exceed the limit established by the state department for individuals receiving a mandatory minimum state supplementation of SSI benefits pursuant to section 26-2-204, C.R.S., or, in the case of a person who is married, do not exceed the amount authorized in section 25.5-6-101, and for whom a licensed physician or advanced practice nurse certifies that such program provides an appropriate alternative to institutionalized care.

(2) Any person who accepts and receives services authorized under this part 5 shall pay to the state department, or to an agent or provider designated by the state department, an amount that shall be the lesser of the person's gross income, minus federally allowed maintenance and medical deductions, or the projected cost of services to be rendered to the person under the case plan. Such amount shall be reviewed and revised as necessary each time the case plan is reviewed.

25.5-6-505. Services for long-term-care eligible persons. (1) Subject to the provisions of this part 5, the home- and community-based services program for persons with HIV/AIDS shall include the following continuum of long-term care services:

- (a) Personal care and homemaker services;
 - (b) Adult day care services;
 - (c) Private duty nursing services;
 - (d) Electronic monitoring services as such term is defined in section 25.5-6-303
- (9);
- (e) Nonmedical transportation services as such term is defined in section 25.5-6-

303 (16);

(f) Services provided under the consumer-directed care model, part 11 of this article.

(2) A long-term-care eligible person receiving home- and community-based services shall remain eligible for the services specified in sections 25.5-5-102, 25.5-5-103, 25.5-5-202, and 25.5-5-203, as applicable.

(3) The provision of the services set forth in subsection (1) of this section shall be subject to the availability of federal matching medicaid funds, pursuant to Title XIX of the federal "Social Security Act", as amended, for payment of the costs for administration and costs for the provision of such services. Case management services shall be reimbursed as an administrative cost.

(4) If the state department or the case management agency makes a determination that the cost for the provision of home- and community-based services necessary to allow an HIV/AIDS client to avoid institutionalization exceeds or would exceed either the average individual medicaid payment for like services for hospital care for clients needing a hospital level of care or the average individual medicaid payment for like services for nursing facility care for clients needing a nursing facility level of care, such client shall not be considered eligible for home- and community-based services.

(5) The location for the provision of home- and community-based services shall be agreed upon by the HIV/AIDS client and the case management agency.

(6) The state department shall implement the provisions of subsection (1) of this section on a case-by-case basis as each service becomes available through approved providers.

(7) No service listed in subsection (1) of this section may be provided to an eligible person unless authorized pursuant to a case plan.

(8) (a) The case management agency, in coordination with the eligible person and the person's family or guardian, shall include in each case plan a process by which the eligible person may receive necessary care, which may include respite care, if the eligible person's family or service provider is unavailable due to an emergency situation or to unforeseen circumstances. The eligible person and the person's family or guardian shall be duly informed by the case management agency of these alternative care provisions at the time the case plan is initiated.

(b) The requirements of this subsection (8) shall not apply if the eligible person is residing in a nursing facility or an alternative care facility.

25.5-6-506. Special provisions - personal care services provided by a family. (1) A member of an eligible person's family, other than the person's spouse, may be employed to provide personal care services to such person.

(2) The maximum reimbursement for the services provided by a member of the

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

25.5-6-507. Duties of state department. (1) In addition to the duties set forth in section 25.5-6-311, the state department shall:

(a) Seek and utilize any available federal, state, or private funds which are available for carrying out the purposes of this part 5, including but not limited to medicaid funds, pursuant to Title XIX of the federal "Social Security Act", as amended;

(b) Provide a system for reimbursement for services provided pursuant to this part 5 that encourages cost containment;

(c) Conduct feasibility studies and pilot programs as the general assembly may from time to time direct to lessen medical costs, including medicaid moneys, associated with persons with HIV/AIDS.

(2) Prior to the submittal of the home- and community-based services medicaid waiver application for this part 5, the state department shall consult with the joint budget committee of the general assembly concerning the proposed number of clients to be served, the savings anticipated, and the costs associated with the implementation of this program.

25.5-6-508. Rules. The executive director and the state board shall promulgate such rules, pursuant to article 4 of title 24, C.R.S., as are necessary to implement this part 5.

PART 6

HOME- AND COMMUNITY-BASED SERVICES FOR PERSONS WITH MAJOR MENTAL ILLNESSES

25.5-6-601. Short title. This part 6 shall be known and may be cited as the "Home- and Community-based Services for Persons with Major Mental Illnesses Act".

25.5-6-602. Legislative declaration - no entitlement created. (1) The general assembly hereby finds and declares that the purpose of this part 6 is to provide, under federal authorization and subject to available appropriations, home- and community-based services for persons with major mental illnesses.

(2) Nothing in this part 6 shall be construed to establish that eligible persons as

defined in section 25.5-6-603 (1) are entitled to receive services from the state department or the department of human services. The provision of any services pursuant to this part 6 shall be subject to federal waiver authorization and available appropriations.

25.5-6-603. Definitions. As used in this part 6, unless the context otherwise requires:

(1) "Eligible person" means a person:

(a) Who has a primary diagnosis of major mental illness, as such term is defined in the diagnostic and statistical manual of mental disorders used by the mental health profession, and includes schizophrenic, paranoid, major affective, and schizoaffective disorders, and atypical psychosis, but does not include dementia, including alzheimer's disease or related disorders;

(b) Who is in need of the level of care available in a nursing facility;

(c) Who is categorically eligible for medical assistance, or whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, and whose resources do not exceed the limit established for individuals receiving a mandatory minimum state supplementation of supplemental security income benefits or, in the case of a person who is married, do not exceed the amount authorized in section 25.5-6-101.

25.5-6-604. Cost of services. Home- and community-based services for persons with major mental illnesses shall meet aggregate federal waiver budget neutrality requirements.

25.5-6-605. Relationship to single entry point for long-term care. The home- and community-based services program for persons with major mental illnesses shall not be considered a publicly funded long-term care program for the purposes of sections 25.5-6-105 to 25.5-6-107, concerning the single entry point system, unless and until the departments of health care policy and financing and human services provide in the memorandum of understanding between the departments for the inclusion of the program in the single entry point system.

25.5-6-606. Implementation of program for mentally ill authorized - federal waiver - duties of the department of health care policy and financing and the department of human services. (1) The state department is hereby authorized to seek any necessary waiver from the federal government to develop and implement a home- and

community-based services program for persons with major mental illnesses. The program shall be designed to provide home- and community-based services to eligible persons. Eligibility may be limited to persons who meet the level of services provided in a nursing facility, and services for eligible persons may be established in state board rules to the extent such eligibility criteria and services are authorized or required by federal waiver. The program shall include services provided under the consumer-directed care service model, part 11 of this article.

(2) The state department and the department of human services shall provide a system of reimbursement for services provided pursuant to this part 6 that encourages the most cost-effective provision of services.

(3) The state department and the department of human services shall, subject to appropriation, use available federal, state, local, or private funds, including but not limited to medicaid funds available under Title XIX of the federal "Social Security Act", as amended, to carry out the purposes of this part 6.

(4) The state department may include in the memorandum of understanding with the department of human services provisions that allow the department of human services to certify agencies as medicaid providers for the purposes of this part 6, to adopt fiscal and administrative procedures, to review plans of care, to recommend reimbursement rates, to make recommendations regarding the scope, duration, and content of programs and the eligibility of persons for specific services provided pursuant to this part 6, and to fulfill any other responsibilities necessary to implement this part 6. However, the provisions shall be consistent with the designation of the state department as the single state agency in section 25.5-4-104.

(5) The executive director and the state board shall promulgate such rules regarding this part 6 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.

(6) The department of human services shall promulgate such rules as are necessary to perform its function pursuant to this part 6. Such rules shall be promulgated in accordance with section 24-4-103, C.R.S., and shall be consistent with the rules of the executive director and the state board.

(7) In the event a direct conflict arises between the rules of the state department promulgated pursuant to subsection (5) of this section and the rules of the department of human services promulgated pursuant to subsection (6) of this section, regarding implementation of this part 6, the rules of the state department shall control.

25.5-6-607. Implementation of part contingent upon receipt of federal waiver - repeal of part. (1) The implementation of this part 6 is conditioned upon the issuance of necessary waivers by the federal government and available appropriations. The

provisions of this part 6 shall be implemented to the extent authorized by federal waiver. The state department shall propose legislation that conforms with the waiver provisions no later than the next regular legislative session following the issuance of the waiver.

(2) Provisions of this part 6 that are approved by the federal government and are authorized by federal waiver shall remain in effect only for so long as specified in the federal waiver, unless otherwise extended by the federal government. The state department shall provide written notice to the revisor of statutes of the final termination date of the waiver, and this part 6 shall be repealed, effective July 1 of the year in which the waiver is terminated.

PART 7

HOME- AND COMMUNITY-BASED SERVICES FOR PERSONS WITH BRAIN INJURY

25.5-6-701. Short title. This part 7 shall be known and may be cited as the "Home- and Community-based Services for Persons with Brain Injury Act".

25.5-6-702. Legislative declaration - no entitlement created. (1) The general assembly hereby finds and declares that the purpose of this part 7 is to provide, under federal authorization and subject to available appropriations, home- and community-based services for persons with brain injury.

(2) Nothing in this part 7 shall be construed to establish that eligible persons as defined in section 25.5-6-703 (4) are entitled to receive services from the state department. The provision of any services pursuant to this part 7 shall be subject to federal waiver authorization and available appropriations.

25.5-6-703. Definitions. 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.

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

(3) "Brain injury" means an injury to the brain arising from external forces including, but not limited to, toxic chemical reactions, anoxia, near drownings, closed or open head injuries, and focal brain injuries.

(4) "Eligible person" means a person:

(a) Who has a diagnosis of brain injury, as such term is defined in subsection (3) of this section;

(b) Who is in need of the level of care available in a hospital, rehabilitation hospital, hospital in lieu of a nursing facility, or is in need of specialized care provided in a nursing facility in lieu of a hospital;

(c) Who is categorically eligible for medical assistance, or has a gross income that does not exceed three hundred percent of the current federal supplemental security income benefit level and resources that do not exceed the limit established for individuals receiving a mandatory minimum state supplementation of supplemental security income benefits or, in the case of a person who is married, do not exceed the amount authorized in section 25.5-6-101; and

(d) For whom the cost of services would not exceed the average cost of hospital care.

(5) "Independent living skills training" means skills and therapies that are directed at the development and maintenance of community living skills and community integration. Independent living skills include supervision or training with respect to or assistance with self-care, communication skills, socialization, sensory and motor development, reducing maladaptive behavior, community living and mobility, and therapeutic recreation.

(6) "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.

(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 to function at the recipient'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.

(8) "Supported living" means assistance or support designed to maximize or maintain independence and self-direction on a supportive care campus. Supported living services consist of structured interventions designed to provide:

- (a) Protective oversight and supervision;
 - (b) Behavioral management and cognitive supports;
 - (c) Interpersonal and social skills development;
 - (d) Improved household management skills to support independence and community integration; and
 - (e) Medical management.
- (9) "Supportive care campus" means a residential campus that provides supported living services.
- (10) "Transitional living" means a nonmedical residential program that provides training and twenty-four-hour supervision to a recipient over a six-to-twelve-month period that will enhance the recipient's ability to live more independently.

25.5-6-704. Implementation of home- and community-based services program for persons with brain injury authorized - federal waiver - duties of the department. (1) (a) The state department is hereby authorized to seek any necessary waiver from the federal government to develop and implement a home- and community-based services program for persons with brain injury. The state department shall design the program to provide home- and community-based services to eligible persons. Eligibility shall be limited to persons who meet the level of services provided in a hospital, rehabilitation hospital, hospital in lieu of nursing facility care, or who are in need of specialized care provided in a nursing facility in lieu of a hospital.

(b) The state department shall seek any necessary amendments to the current federal waiver for the home- and community-based services program for persons with brain injury to allow supported living, as defined in section 25.5-6-703 (8), to be provided to eligible persons on a supportive care campus.

(2) Services for eligible persons may be established in department rules to the extent authorized or required by federal waiver, but shall include at least the following:

(a) Independent living skills training, as indicated in the eligible person's plan of care, and provided by local agencies determined by the department to be qualified to provide the services;

(b) Residential care including, but not limited to:

(I) Transitional living;

(II) Respite care;

(III) Supported living;

(c) Personal care services;

(d) Assisted transportation;

(e) Counseling and training including substance abuse treatment and family counseling;

(f) Environmental modification services;

(g) Day care, which may include physical, occupational, and speech therapies as indicated in the eligible person's plan of care;

(h) Structured day treatment, which may include physical, occupational, speech, and cognitive therapies if deemed necessary by the eligible person's case manager and as indicated in the person's plan of care. Structured day treatment services are for individuals who may benefit from continued rehabilitation and reintegration into the community.

(i) Behavioral programming that may be provided in or outside an eligible person's residence;

(j) Assistive technology;

(k) Services provided under the consumer-directed care service model, part 11 of this article.

(3) The case manager, in coordination with the eligible person and the person's family or guardian, shall include in each plan of care a process by which the eligible person may receive necessary care, which may include respite care, if the eligible person's family or service provider is unavailable due to an emergency situation or to unforeseen circumstances. The eligible person and the person's family or guardian shall be duly informed by the case manager of these alternative care provisions at the time the plan of care is initiated.

(4) (a) The department shall provide a system of reimbursement for services provided pursuant to this part 7 that encourages the most cost-effective provision of services.

(b) A member of an eligible person's family, other than the person's spouse or a parent of a minor, may be employed to provide personal care services to such person. The maximum reimbursement for the services provided by a member of the person's family per year for an eligible person shall not exceed the equivalent of four hundred forty-four service units per year for a member of the eligible person's family. Standards that apply to other providers who provide personal care services apply to a family member who provides these services. In addition, a registered nurse shall supervise a family member in providing services to the extent indicated in the eligible person's plan of care.

(5) The state department shall, subject to appropriation, use available federal, state, local, or private funds including, but not limited to, medicaid funds available under Title XIX of the federal "Social Security Act", as amended, to carry out the purposes of this part 7.

(6) The state board shall adopt rules concerning the certification of agencies as medicaid providers for the purposes of this part 7, fiscal and administrative procedures, procedures for reviewing plans of care, reimbursement rates, and the scope, duration, and content of programs and the eligibility for specific services provided pursuant to this part 7. The state board shall adopt such rules 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.

25.5-6-705. Implementation of part contingent upon receipt of federal waiver - repeal of part. (1) (a) The implementation of this part 7 is conditioned upon the issuance of necessary waivers by the federal government and available appropriations. The provisions of this part 7 shall be implemented to the extent authorized by federal waiver. The state department shall propose legislation that conforms with the waiver provisions no later than the next regular legislative session following the issuance of the waiver.

(b) The implementation of the provisions of this part 7 relating to services provided on a supportive care campus are conditioned upon the approval of necessary waiver amendments by the federal government. The provisions of this part 7 relating to supported living shall be implemented to the extent authorized by federal waiver and in accordance with applicable federal requirements.

(2) Provisions of this part 7 that are approved by the federal government and are authorized by federal waiver shall remain in effect only for so long as specified in the federal waiver, unless otherwise extended by the federal government. The state department shall provide written notice to the revisor of statutes of the final termination date of the waiver, and this part 7 shall be repealed, effective July 1 of the year in which the waiver is terminated.

25.5-6-706. Rate structure - rules - quality assurance. (1) (a) The state board, by rule, shall set tiered per diem rates for services provided on a supportive care campus under this part 7. When structuring the tiered per diem rates, the state board shall consider the medical and cognitive needs of eligible persons being served on the supportive care campus.

(b) The maximum per diem rate for the services provided on a supportive care campus shall not exceed the total per diem cost of comparable populations either in institutions or in other community-based settings.

(2) The state board shall adopt rules necessary for quality assurance, which shall include certification of supportive care campuses.

PART 8

HOME- AND COMMUNITY-BASED SERVICES FOR CHILDREN WITH AUTISM

25.5-6-801. Short title. This part 8 shall be known and may be cited as the "Home- and Community-based Services for Children with Autism Act".

25.5-6-802. Definitions. As used in this part 8, unless the context otherwise requires:

- (1) "Eligible child" means a child who:
 - (a) Is eligible for the state's medicaid program pursuant to section 25.5-5-101, 25.5-5-201, or 25.5-5-203;
 - (b) Is age birth to six years;
 - (c) Has a diagnosis of autism;
 - (d) Is at risk of institutionalization in either an intermediate care facility for individuals with intellectual disabilities, a hospital, or a nursing facility; and
 - (e) Is not receiving services from any of the alternatives to long-term care waiver programs established in this title.
- (2) "Lead provider" means the credentialed, certified, or licensed professional who is the eligible child's primary provider and who is responsible for supervision of the eligible child's care plan.
- (3) "Services" means the home- and community-based services provided pursuant to this part 8.

25.5-6-803. Federal authorization - budget neutrality - available appropriations. (1) The state department shall seek the federal authorization necessary to implement the provisions of this part 8.

(2) Home- and community-based services for children with autism shall meet aggregate federal waiver budget neutrality requirements.

(3) (a) The provision of services pursuant to this part 8 is subject to available appropriations from the Colorado autism treatment fund established in section 25.5-6-805.

(b) The provision of home- and community-based services pursuant to this part 8 shall be subject to the availability of federal matching medicaid funds, pursuant to Title XIX of the federal "Social Security Act", as amended, for payment of the costs for administration and the costs for the provision of such services.

(4) The state department shall:

(a) Seek and utilize any available federal, state, or private funds which are available for carrying out the purposes of this part 8, including but not limited to medicaid funds pursuant to Title XIX of the federal "Social Security Act", as amended;

(b) Provide a system of reimbursement for services that encourages the most cost-effective provision of services.

25.5-6-804. Services - duties of the state department - rules. (1) Subject to the

provisions of this part 8, home- and community-based services for children with autism shall include only the following services, as specified in the eligible child's care plan:

- (a) Occupational therapy;
- (b) Speech therapy;
- (c) Psychological and psychiatric services;
- (d) Physical therapy;
- (e) Behavioral therapy; and
- (f) Services provided under the consumer-directed care service model, part 11 of this article.

(2) No eligible child may receive services in an amount in excess of twenty-five thousand dollars annually.

(3) The state department shall utilize the services of existing service provider agencies to provide services pursuant to this part 8. A service provider agency shall retain no more than fifteen percent of the established service reimbursement rate for administrative costs.

(4) A care planning agency may be certified to provide the services described in subsection (1) of this section if otherwise qualified as a provider under the state medical assistance program.

(5) The state department shall contract with a community centered board for persons with developmental disabilities to serve as the single entry point agency for services and as the care planning agency for eligible children. If a community centered board is unwilling or unable to enter into the contract with the state department, the state department may contract with a single entry point agency identified pursuant to section 25.5-6-106 or a state-department-approved case management agency to serve as the entry point agency and as the care planning agency. The care planning process shall include the eligible child's family or guardian, the eligible child's lead provider, and the eligible child's case manager. For the purpose of implementing this part 8 the care planning process shall be coordinated with any other care plan or case manager the eligible child may have.

(6) A member of an eligible child's family may be employed to provide services to the child. The reimbursement limitation in section 25.5-6-310 shall not apply to services provided pursuant to this part 8 by a family member.

(7) The state department shall develop the service provisions, which shall include provisions for the supervision of direct care providers, and the care planning process under this part 8 in consultation with parents of children with autism and medical professionals who have expertise in treating children with autism.

(8) (a) The state board shall adopt rules necessary to implement and administer the provisions of this part 8, including but not limited to requiring an ongoing evaluation process for each eligible child and the use of an external evaluation contractor for this purpose.

(b) An eligible child participating in services pursuant to this part 8 shall be evaluated at entry into the program, at least every six months during the course of services, and at the termination of services pursuant to this part 8. The evaluations shall include, but need not be limited to:

(I) An assessment of the eligible child's expressive and receptive communication through the use of a standardized and norm-referenced assessment as determined by the state department through rule;

(II) An assessment of the eligible child's adaptive skills including self-help skills through the use of a norm-referenced and standardized assessment as determined by the state department through rule; and

(III) An assessment of the severity of the eligible child's maladaptive behavior, including self-injurious or aggressive behaviors or tantrums, through the use of a norm-referenced and standardized assessment as determined by the state department through rule.

(c) The evaluations shall be conducted pursuant to the provisions of paragraph (b) of this subsection (8) by the child's lead therapist or other trained professionals as designated by the department.

(d) The evaluator shall provide a copy of the evaluation, including any supporting data, to the eligible child's parent or legal guardian and to the agency responsible for the eligible child's care planning. The agency responsible for the eligible child's care planning shall retain a copy of the eligible child's evaluation and supporting data.

(e) Any costs associated with the evaluations required pursuant to this subsection (8) shall be included within the annual cost limitation on services set forth in subsection (2) of this section. Evaluations of an eligible child may be conducted through the eligible child's school or with other resources that are not part of the services provided pursuant to this part 8, so long as the evaluations are consistent with the provisions of paragraph (b) of this subsection (8).

(f) The ongoing evaluation of children receiving services under the program pursuant to this subsection (8) shall not be used to alter a child's eligibility to participate in the program.

(9) The state department shall annually review the available balance in the Colorado autism treatment fund, created pursuant to section 25.5-6-805, to determine whether additional eligible children may be provided services pursuant to this part 8 consistent with existing federal authorization.

(10) So long as children who are determined eligible for the autism waiver program are on a wait list to receive services, the state department's priority shall be to move off of the wait list and into the autism waiver program those children who are determined to have an imminent need for services as determined through an objective assessment process. The state department's objective assessment process for determining imminent need for services under the autism waiver program shall incorporate norm-

referenced autism assessment findings and prioritize children based on the severity of the child's assessed condition. This subsection (10) shall apply only upon the approval by the centers for medicare and medicaid services that it is consistent with federal law.

25.5-6-805. Colorado autism treatment fund. (1) The Colorado autism treatment fund is hereby created and established in the state treasury for the purpose of paying for services provided to eligible children and for participant and program evaluations pursuant to this part 8. Such fund shall be comprised of tobacco settlement moneys allocated to such fund. Moneys in the fund shall be subject to annual appropriation by the general assembly for the purposes of this part 8. At the end of any fiscal year, all unexpended and unencumbered moneys in the fund shall remain therein and shall not be credited or transferred to the general fund or any other fund. Any moneys in the fund not expended for the purpose of this part 8 may be invested by the state treasurer as provided by law. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund.

(2) Pursuant to section 24-75-1104.5 (1) (I), C.R.S., beginning in the 2008-09 fiscal year and in each fiscal year thereafter so long as the state receives moneys pursuant to the master settlement agreement, the state treasurer shall annually transfer to the fund the amount of moneys to be received by the fund pursuant to section 24-75-1104.5 (1) (I), C.R.S. The state treasurer shall transfer the amount specified in this subsection (2) from moneys credited to the tobacco litigation settlement cash fund created in section 24-22-115, C.R.S.

25.5-6-806. Autism waiver - program evaluation. (1) As provided in subsection (2) of this section, the state department shall submit written program evaluations to the health and environment committee of the house of representatives, or any successor committee, and to the health and human services committee of the senate, or any successor committee, concerning home- and community-based services provided to children with autism pursuant to this part 8. The state department shall determine the appropriate process and procedures for conducting the evaluation, including procedures to protect a program participant's individually identifying information.

(2) (a) On or before June 1, 2013, the state department's evaluation shall include, at a minimum, information concerning:

(I) The number of eligible children receiving services or who have received services under the waiver program;

(II) The average and median age of eligible children when they begin receiving services and the average length of time that children receive services; and

(III) The average cost of services provided to an eligible child.

(b) On or before June 1, 2014, the state department's evaluation shall include, at a minimum, information concerning the design and implementation of the ongoing evaluation process pursuant to section 25.5-6-804 (8).

(c) (I) On or before June 1, 2015, the state department's evaluation shall include an evaluation of eligible children's care plans and evaluations conducted at the beginning and ending of services, as well as ongoing evaluations during the course of services, to determine whether home- and community-based services provided pursuant to this part 8 are effective in meeting the goals of the waiver program, which goals include, but are not limited to:

(A) Serving the children most vulnerable to institutionalization without the services provided pursuant to this part 8;

(B) Keeping children out of institutions; and

(C) Demonstrating improvement in the child's expressive and receptive communication, adaptive skills, such as dressing and toileting, and a reduction in the severity of the child's maladaptive behavior, including self-injurious or aggressive behavior and tantrums, through the use of standardized and norm-referenced assessments.

(II) The state department may contract with an independent program evaluator with expertise in reviewing treatment progress reports, individual evaluations, and medical records for purposes of conducting the evaluation pursuant to this paragraph (c) concerning the effectiveness of the home- and community-based services provided pursuant to this part 8.

PART 9

HOME- AND COMMUNITY-BASED SERVICE PROGRAMS FOR CHILDREN

25.5-6-901. Disabled children care program - eligibility criteria - documentation requirements - report to the general assembly. (1) The general assembly hereby finds and declares that a program shall be established by the state department to provide services not otherwise available to eligible disabled children outside the confines of an acute care hospital or nursing facility. Such program shall be known as the "disabled children care program" and shall be designed to safely provide services to eligible disabled children in a home- or community-based setting at a cost to the medicaid program equal to or less than the medicaid cost of inpatient hospital or nursing facility care.

(2) (a) The state department is authorized to seek a waiver from the federal department of health and human services to qualify for federal financial participation in the disabled children care program. Application for such waiver is contingent upon a

finding that continuation of the disabled children care program results in less expenditures from the general fund than if such program were terminated.

(b) If federal financial participation is secured, eligibility for participation in the program and the number of children to be served under the program shall be in accordance with federal regulations.

(3) (a) "Eligible disabled children" means any children eighteen years of age and under who:

(I) Have medical needs which would qualify them, pursuant to state department criteria, for institutionalization or place them at risk for institutionalization in any one of the following: An acute care hospital or a nursing facility; and

(II) Have gross incomes which do not exceed three hundred percent of the current federal supplemental security income benefit level. The amount of parental or spousal income and resources which shall be attributable to a child's gross income for purposes of eligibility shall be set forth in rules promulgated by the state board and shall be in relation to the parent's or spouse's financial responsibility for such child; and

(III) Are not receiving services from any of the alternatives to long-term care waiver programs established under this title.

(b) "Home care services" means all services available under sections 25.5-5-102, 25.5-5-103, 25.5-5-202, and 25.5-5-203 that may be received in a noninstitutional setting.

(4) (a) The state department shall require the following documentation on each applicant for the program:

(I) An assessment by the disabled child's attending physician of the child's medical, functional, and social status and a determination by such physician that the quality of care which can be provided in the noninstitutional setting is equal to or exceeds the quality of care the child could receive in an acute care hospital or nursing facility;

(II) An analysis of the cost of services for the disabled child in an institutional setting as compared to the cost of such services in a noninstitutional setting;

(III) An assessment of the caregiver's ability to provide the needed services to the disabled child in a noninstitutional setting and an assessment of such caregiver's social history.

(b) The information required under paragraph (a) of this subsection (4) shall be collected and reviewed by the state department at least every six months for disabled children who enter the disabled children care program in order to ensure that the quality of noninstitutional care continues to equal or exceed such care in an institutional setting and that the costs for care under the program are less than the costs for such care in an institution. When the disabled child is found to no longer qualify for institutionalization or be at risk for institutionalization pursuant to state department criteria, the child shall no longer be eligible for the disabled children care program.

25.5-6-902. Children's personal assistance services and family support program. (1) The general assembly finds that many families who attempt to care for severely disabled or terminally ill children at home often are burdened with the excessive financial and personal costs of providing continuous care. Private insurance companies rarely support essential, long-term custodial services and often establish monetary limits that are well below the levels required by these disabled children. When coverage is available, care is frequently provided in a medical model that is marginally appropriate to the needs of the children and the family and usually more expensive to the payor. The resulting pressures often contribute to family disintegration and increased dependency on public programs. The general assembly finds that it is in the best interests of the citizens of the state to encourage the preservation of families with children with disabilities.

(2) As used in this section, unless the context otherwise requires, "eligible disabled children" means children eighteen years of age or younger:

(a) Who have medical needs that, pursuant to state department rules, would qualify them for institutionalization or place them at risk of institutionalization in an acute care hospital or nursing facility;

(b) Who have gross incomes, including the amount of parental income and resources to be attributed to the child's gross income according to rules to be promulgated by the state board, that do not exceed three hundred percent of the current federal supplemental security income benefit level;

(c) Who are not receiving long-term services from any alternative waiver program established under this title;

(d) For whom a licensed physician or an advanced practice nurse has certified that in-home care is an appropriate way to meet the child's needs; and

(e) For whom the cost of care outside of the institution is no higher than the estimated medicaid cost of appropriate institutional care.

(3) There is hereby established in the state department the children's personal assistance services and family support waiver program, referred to in this section as the "program", to provide services to eligible disabled children in their homes rather than in the confines of an acute care hospital or nursing facility. The number of children enrolled in this program or any other model 200 program shall not exceed the state department's ability to cover the costs of the programs within the annual appropriations for this program and any other model 200 program.

(4) Priority for participation in the program shall be given first to children who are on the waiting list for other model 200 programs and secondly to children whose parents will return to work if appropriate care for their disabled child is provided under the program. Spaces in the program shall also be available to children who were already covered by medicaid but who were rendered temporarily ineligible for a period of not more than three months due to a periodic or cyclical peak in their parents' income.

(5) The state board shall adopt rules to govern the program consistent with any

federal waivers including, but not limited to, rules concerning:

(a) Services that are reimbursable under this section including, but not limited to:

(I) Respite care, to the degree its additional cost is offset by collection of a parental copayment;

(II) Case management; and

(III) Medically necessary professional or community services beyond those specified in section 25.5-5-102 or 25.5-5-202, to the degree that they provide a cost-effective and medically appropriate alternative to covered services;

(b) Provider selection and certification;

(c) Documentation for assessment and recertification;

(d) Case management agency selection and responsibility; and

(e) Reimbursement.

(6) The case management agency, in coordination with the eligible disabled child's family and the child's physician, shall include in each case plan a process by which the eligible disabled child may receive necessary care, which may include respite care, if the eligible disabled child's family or care provider is unavailable due to an emergency situation or to unforeseen circumstances. The eligible disabled child's family shall be duly informed by the case management agency of these alternative care provisions at the time the case plan is initiated.

(7) If the state department finds it cost-effective and all necessary federal waivers are obtained, parents of eligible disabled children may be authorized to hire and manage care providers from certified medicaid agencies. Case management agencies shall work with parents to develop the skills necessary for ongoing care management.

(8) The state department is authorized to seek waivers from the federal government to qualify for federal financial participation in the program.

(9) The state department is authorized to charge and collect copayments from parents for services rendered.

(10) The state department is directed to study the advisability of setting an upper limit on parental income for participation in this program and other children's medicaid waiver programs.

PART 10

CONSUMER-DIRECTED ATTENDANT SUPPORT FOR PERSONS WITH DISABILITIES

25.5-6-1001 to 25.5-6-1004. (Repealed)

PART 11

CONSUMER-DIRECTED CARE

25.5-6-1101. Definitions. As used in this part 11, unless the context otherwise requires:

(1) "Attendant support" means any action to assist an eligible person in accomplishing activities of daily living, instrumental activities of daily living, and habilitative and health-related tasks. Such activities include, but are not limited to, personal care services, household services, cognitive services, mobility services, and health-related tasks.

(2) "Authorized representative" means an individual designated by the eligible person, by the parent of a minor, or by the legal guardian of the eligible person if the eligible person cannot demonstrate sound judgment to his or her primary care physician, who has the judgment and ability to assist the eligible person in acquiring and utilizing services under this part 11. The extent of the authorized representative's involvement shall be determined upon designation.

(3) "Consumer-directed" means that an eligible person receives a direct payment through a voucher and employs, trains, and in other ways manages the person who provides his or her attendant support. The direct payment through a voucher that is received by an eligible person to pay for attendant support shall not be counted as income for purposes of determining eligibility for medicaid and other state programs that use income to determine eligibility.

(4) "Eligible person" means a person who is eligible to receive services under parts 3 to 12 of this article or any other home- and community-based service waiver for which the state department has federal waiver authority.

(5) "Primary care physician" means a physician who is the primary provider of physician services to the eligible person or who is familiar with the eligible person's needs and capabilities.

(6) "Qualified services" means services provided under the eligible person's applicable waiver program and attendant support.

25.5-6-1102. Service model - consumer-directed care. (1) The state department shall implement a consumer-directed care service model that allows eligible persons to receive a direct payment through a voucher to purchase qualified services. The state department is authorized to seek any federal waivers or waiver amendments that may be necessary to implement this part 11. The state department shall design and implement the consumer-directed care service model with input from consumers of home- and community-based services or their authorized representatives. An eligible person shall not

be required to disenroll from the person's waiver program in order to receive qualified services through the consumer-directed care service model.

(2) In order to qualify and to remain eligible for the consumer-directed care service model authorized by this section, a person shall:

(a) Be eligible for home- and community-based services under parts 3 to 12 of this article or any other home- and community-based service waiver for which the state department has federal waiver authority;

(b) Be willing to participate;

(c) Obtain a statement from his or her primary care physician or advanced practice nurse indicating that the person has sound judgment and the ability to direct his or her care or has an authorized representative;

(d) Demonstrate the ability to handle the financial aspects of self-directed care or has an authorized representative who is able to handle the financial aspects of the eligible person's care; and

(e) Meet any other qualifications established by the state board by rule.

(3) The voucher issued to the eligible person under this part 11 shall be based on the eligible person's historical utilization of home- and community-based services under parts 3 to 12 of this article, the single entry point agency's care plan, or any approved resource allocation process as determined by the state department and the department of human services for the eligible person.

(4) While an eligible person is participating in the consumer-directed care service model established in this part 11, that person shall be ineligible to receive a home care allowance as provided in section 26-2-122.3 (1) (b), C.R.S.

(5) The state department shall develop the accountability requirements necessary to safeguard the use of public dollars, to promote effective and efficient delivery of services, and to monitor the safety and welfare of eligible persons under this part 11.

(6) The state board shall adopt rules as necessary for the implementation and administration of the consumer-directed care service model authorized by this part 11. Such rules shall include a provision allowing an eligible person to designate a family member or authorized representative to be responsible for managing the financial matters associated with the consumer-directed care or to direct the eligible person's care. The designee shall not receive reimbursement for managing the financial matters associated with the eligible person's care or for directing the eligible person's care.

(7) Sections 12-38-103 (8), 12-38-103 (11), 12-38-123 (1) (a), 12-38.1-102 (5), and 12-38.1-117 (1) (b), C.R.S., shall not apply to a person who is directly employed by an individual participating in the consumer-directed care service model pursuant to this section and who is acting within the scope and course of such employment. However, such person may not represent himself or herself to the public as a licensed nurse, a certified nurse aide, a licensed practical or professional nurse, a registered nurse, or a registered professional nurse. This exclusion shall not apply to any person who has had

his or her license as a nurse or certification as a nurse aide suspended or revoked or his or her application for such license or certification denied.

(8) Section 25.5-6-310 does not apply to a family member of an eligible person who provides consumer-directed care services to the eligible person pursuant to this part 11.

(9) A person who has been designated as an authorized representative under this part 11 shall submit an affidavit, which shall become part of the eligible person's file, stating that:

- (a) He or she is at least eighteen years of age;
- (b) He or she has known the eligible person for at least two years;
- (c) He or she has not been convicted of any crime involving exploitation, abuse, or assault on another person; and
- (d) He or she does not have a mental, emotional, or physical condition that could result in harm to the eligible person.

25.5-6-1103. Reporting. (1) The state department shall provide a report to the joint budget committee of the general assembly and the health and human services committees of the house of representatives and the senate, or any successor committees, by October 1, 2006, that includes, but is not limited to, the following:

- (a) The number of elderly persons participating in the consumer-directed care program;
- (b) The cost-effectiveness of the consumer-directed care program;
- (c) Feedback from consumers and the state department concerning the progress and success of the consumer-directed care program; and
- (d) Any changes to the health status or health outcomes of the program participants.

PART 12

IN-HOME SUPPORT SERVICES

25.5-6-1201. Legislative declaration. 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 and to disabled children 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 care needs and remain living in the community. The general assembly, therefore,

declares that it is beneficial to the elderly, blind, and disabled clients of home- and community-based services and to clients of the disabled children care program for the state department to develop a service that would allow these people to receive in-home support.

25.5-6-1202. Definitions. As used in this part 12, unless the context otherwise requires:

(1) "Attendant" means a person who is directly employed by an in-home support service agency to provide or a family member providing in-home support services to eligible persons.

(2) "Authorized representative" means an individual designated by the eligible person receiving services, or by the parent or guardian of the eligible person receiving services, if appropriate, who has the judgment and ability to assist the eligible person receiving services in acquiring and utilizing services under this part 12. The extent of the authorized representative's involvement shall be determined upon designation. The authorized representative shall not be the eligible person's service provider.

(3) "Eligible person" means any person who:

(a) Is eligible for home- and community-based services under part 3 of this article or is eligible for the disabled children care program under section 25.5-6-901;

(b) Is willing to participate;

(c) Obtains a statement from his or her primary care physician indicating that the person has sound judgment and the ability to direct his or her care, the eligible child's parent or guardian has sound judgment and the ability to direct the eligible child's care, or the person has an authorized representative; and

(d) Meets any other qualifications established by the state board by rule.

(4) "Health maintenance activities" means health-related tasks as defined in rule by the state board and include, but are not limited to, catheter irrigation, administration of medication, enemas, and suppositories, and wound care.

(5) "In-home support service agency" means an agency that is certified by the state department and provides independent living core services as defined in section 26-8.1-102 (3), C.R.S., and in-home support services.

(6) "In-home support services" means services that are provided by an attendant and include health maintenance activities, support for activities of daily living or instrumental activities of daily living, personal care services as defined in section 25.5-6-303 (18), and homemaker services as defined in section 25.5-6-303 (11).

25.5-6-1203. In-home support services - eligibility - licensure exclusion - in-home support service agency responsibilities. (1) The state department shall offer in-

home support services as an option for eligible persons who receive home- and community-based services. In-home support services shall be provided to eligible persons. The state department shall seek any federal authorization that may be necessary to implement this part 12. The state department shall design and implement in-home support services with input from consumers of home- and community-based services and independent living centers and home- and community-based service providers.

(2) An eligible person receiving in-home support services or the eligible person's authorized representative or parent or guardian shall be allowed to choose the eligible person's in-home support service agency or the eligible person's attendant.

(3) Sections 12-38-103 (8), 12-38-103 (11), 12-38-123 (1) (a), 12-38.1-102 (5), and 12-38.1-117 (1) (b), C.R.S., shall not apply to a person who is directly employed by an in-home support service agency to provide in-home support services and who is acting within the scope and course of such employment or is a family member providing in-home support services pursuant to this part 12. However, such person may not represent himself or herself to the public as a licensed nurse, a certified nurse aide, a licensed practical or professional nurse, a registered nurse, or a registered professional nurse. This exclusion shall not apply to any person who has had his or her license as a nurse or certification as a nurse aide suspended or revoked or his or her application for such license or certification denied.

(4) (a) In-home support service agencies providing in-home support services shall provide twenty-four-hour back-up services to their clients. 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.

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

(5) The single entry point agencies established in section 25.5-6-106 shall be 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 single entry point agencies' responsibilities under this part 12. At a minimum, these rules shall require that case managers discuss the option and potential benefits of in-home

support services with all eligible long-term care clients.

(6) Section 25.5-6-310 does not apply to any parent who provides in-home support services to an eligible disabled child pursuant to this part 12.

(7) In administering the provision of in-home support services pursuant to this part 12, the state department shall:

(a) Implement a system for the routine and accurate monitoring of the number of persons receiving in-home support services; and

(b) Provide comprehensive, periodic training for all single entry point agencies in the state, which training shall include, at a minimum:

(I) The current eligibility requirements for the receipt of in-home support services; and

(II) The location of, and contact information for, the in-home support service agencies providing in-home support services in the state.

25.5-6-1204. Provision of services - duties of state department - gifts - grants. (1) The provision of the in-home support services set forth in this part 12 shall be subject to the availability of federal matching medicaid funds, pursuant to Title XIX of the federal "Social Security Act", as amended, for payment of the costs for administration and the costs for the provision of such services.

(2) The state department shall seek and utilize any available federal, state, or private funds that are available for carrying out the purposes of this part 12, including but not limited to medicaid funds, pursuant to Title XIX of the federal "Social Security Act", as amended.

(3) The executive director of the state department is authorized to accept and expend on behalf of the state any grants or gifts from any public or private source for the purpose of implementing this part 12.

25.5-6-1205. Accountability - rate structure - rules. (1) The state department shall develop the accountability requirements necessary to safeguard the use of public dollars and to promote effective and efficient service delivery under this part 12.

(2) The state board, by rule, shall set a separate rate structure for in-home support services provided under this part 12.

(3) The state board shall adopt rules as necessary for the implementation and administration of the in-home support services authorized by this part 12. At a minimum, the rules shall include certification of in-home support service agencies and standards of care for the provision of services under this part 12.

25.5-6-1206. Report. The state department shall report annually to the joint budget committee of the general assembly and the health and human services committee of the senate, or any successor committee, and the health and environment committee of the house of representatives, or any successor committee, on the implementation of in-home support services. At a minimum the report shall include the cost-effectiveness of providing in-home support services to the elderly, blind, and disabled and to eligible disabled children, the number of persons receiving such services, and any strategies and resources that are available or that are necessary to assist more persons in staying in their homes through the use of in-home support services.

25.5-6-1207. Repeal of part. This part 12 is repealed, effective September 1, 2014. Prior to such repeal, in-home support services established under this part 12 shall be reviewed as provided for in section 24-34-104, C.R.S.

25.5-6-1208. Conditional repeal of part. (Repealed)

PART 13

COMPLEMENTARY AND ALTERNATIVE THERAPIES
FOR A PERSON WITH A SPINAL CORD INJURY

25.5-6-1301. Legislative declaration. (1) The general assembly finds that:

- (a) A person with a spinal cord injury could benefit from complementary and alternative therapies such as chiropractic care, massage therapy, or acupuncture; and
- (b) Complementary and alternative therapies could improve the quality of life and help reduce the need for continuous or more expensive procedures, medications, and hospitalizations for a person with a spinal cord injury and could allow a person with a spinal cord injury to be employed.

25.5-6-1302. Definitions. As used in this part 13, unless the context otherwise requires:

(1) "Complementary or alternative therapy" means a form of diverse health care therapy not provided for under this article or article 4 or 5 of this title prior to August 5, 2009, but authorized by the rules of the state board adopted pursuant to section 25.5-6-1303 (4). The therapy shall be limited to chiropractic care, massage therapy, and acupuncture performed by licensed or certified providers.

(2) "Eligible person with a disability" means a person with a disability who meets the eligibility criteria specified in section 25.5-6-1303 (2) (b).

(3) "Pilot program" means the pilot program authorized pursuant to section 25.5-6-1303 to allow an eligible person with a disability to receive complementary and alternative therapies.

25.5-6-1303. Pilot program - complementary or alternative therapies - rules. (1) The general assembly authorizes the state department to implement a pilot program that would allow an eligible person with a disability to receive complementary or alternative therapies to the extent authorized by federal waiver. The pilot program shall begin no later than January 1, 2012. The state department shall design and implement the pilot program with input from an advisory committee that shall include, but need not be limited to, persons with spinal cord injuries who are receiving complementary or alternative therapies. The state department is authorized to seek any federal waivers that may be necessary to implement this part 13.

(2) (a) The purpose of the pilot program shall be to expand the choice of therapies available to eligible persons with disabilities, to study the success of complementary and alternative therapies, and to produce an overall cost savings for the state compared to the estimated expenditures that would have otherwise been spent for the same persons with spinal cord injuries absent the pilot program.

(b) In order to qualify and to remain eligible for the pilot program authorized by this section, a person shall:

- (I) Be diagnosed with a spinal cord injury;
- (II) Be willing to participate in the pilot program;
- (III) Demonstrate a current need, as further defined in rule by the state board, for complementary or alternative therapies; and
- (IV) Be eligible for medicaid, including but not limited to persons whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level and who are eligible for a home- and community-based program authorized pursuant to this title or the consumer-directed attendant support pilot program authorized pursuant to part 10 of article 6 of this title.

(3) The state department shall develop the accountability requirements for the pilot program necessary to safeguard the use of public moneys and to promote effective and efficient service delivery.

(4) The state board shall adopt rules as necessary for the implementation and administration of the pilot program.

(5) The state department shall cause to be conducted an independent evaluation of the pilot program to be completed by the end of the third year of the pilot program. The state department shall provide a report of the evaluation to the health and human services

committees of the senate and the house of representatives, or any successor committees, by August 1, 2015. The report on the evaluation shall include the following:

(a) The number of eligible persons with disabilities participating in the pilot program;

(b) The cost-effectiveness of the pilot program;

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

(d) Any changes to the health status or health outcomes of the persons participating in the pilot program;

(e) Other information relevant to the success and problems of the pilot program; and

(f) Recommendations concerning the feasibility of continuing the pilot program beyond the pilot stage and changes, if any, that are needed.

(6) The state department is authorized to seek and accept gifts, grants, or donations from private or public sources for the purposes of this part 13; except that the state department shall not accept a gift, grant, or donation if it is subject to conditions that are inconsistent with this part 13 or any other law of the state. The state department shall transmit all private and public moneys received through gifts, grants, or donations to the state treasurer, who shall credit the same to the department of health care policy and financing cash fund created pursuant to section 25.5-1-109.

(7) Unless the state department receives sufficient moneys from either the general fund or from gifts, grants, and donations made pursuant to subsection (6) of this section, the state department shall not be required to seek federal approval or implement the pilot program.

25.5-6-1304. Repeal of part. This part 13 is repealed, effective September 1, 2015.

PART 14

MEDICAID BUY-IN

25.5-6-1401. Legislative declaration. The general assembly hereby declares its support for the full employment of people with disabilities. It is the general assembly's intent to enact this part 14 for the purpose of allowing an individual with disabilities to purchase medicaid coverage that will enable the individual to maintain employment without losing his or her medicaid benefits.

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. 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.

(2) "Family" means an individual, the individual's spouse, and any dependent child of the individual.

(3) "Health insurance" means surgical, medical, hospital, major medical, or other health service coverage, including a self-insured health plan, but does not include hospital indemnity policies or ancillary coverages such as income continuation, loss of time, or accident benefits.

(4) "Medicaid buy-in program" means a program that gives each person with disabilities the opportunity to buy into medicaid if the person meets the eligibility criteria specified in section 25.5-6-1404.

(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. 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.

25.5-6-1403. Waivers and amendments. (1) On or before January 1, 2010, the state department shall submit to the joint budget committee of the general assembly a report on the actuarial study and the fiscal analysis of the premiums based on the study and the rules adopted pursuant to this section.

(2) If approved by the joint budget committee following its review of the report and subject to available appropriations, the state department shall submit to the federal centers for medicare and medicaid services an amendment to the state medical assistance plan, and shall request any necessary waivers from the secretary of the federal department of health and human services, to permit the state department to expand medical assistance eligibility as provided in this part 14 for the purpose of implementing a medicaid buy-in

program for people with disabilities who are in the basic coverage group or the medical improvement group. In addition, the state department shall apply to the secretary of the federal department of health and human services for a medicaid infrastructure grant, if available, to develop and implement the federal "Ticket to Work and Work Incentives Improvement Act of 1999", Pub.L. 106-170.

(3) If the state medical assistance plan amendment and all necessary waivers are approved, the state department shall implement the medicaid buy-in program provided in this part 14 not later than three months after receiving full federal approval, whichever is later.

25.5-6-1404. Medicaid buy-in program - eligibility - premiums - medicaid buy-in cash fund - report. (1) **Eligibility.** An individual is eligible for and shall receive medicaid provided in this part 14 through a medicaid buy-in program without losing eligibility for medicaid if all of the following conditions are met:

(a) The individual meets the requirements for the basic coverage group or the individual was previously in the basic coverage group and now meets the requirements for the medical improvement group;

(b) The individual maintains premium payments calculated by the state department in accordance with subsection (3) of this section, unless the individual is exempted from premium payments under rules promulgated by the state board; and

(c) The individual meets all other requirements established by rule of the state board.

(2) There is no income or asset limitation for a participant in the medicaid buy-in program. In addition, there is no income or asset limitation for an individual who participates in the medicaid buy-in program and also receives home- and community-based services.

(3) **Premiums.** (a) An individual who is eligible for and receives medicaid under subsection (1) of this section shall pay a premium pursuant to a payment schedule established by the state department. The amount of the premium shall be determined from a sliding-fee scale adopted by rule of the state board that is based on a percentage of the individual's income adjusted for family size and on any impairment-related work expenses; except that, consistent with federal law, if the amount of the individual's adjusted gross income exceeds seventy-five thousand dollars, the individual shall be responsible for paying one hundred percent of the premium. The actuarial study shall also consider contributions from employers pursuant to paragraph (b) of subsection (4) of this section. The rules shall specify the amount of unearned income the state department shall disregard in calculating the individual's income.

(b) The rules setting the premiums and the sliding-fee scale shall be based on an actuarial study of the disabled population in this state. The state department may solicit

and accept federal grants to cover the costs of the actuarial study. Moneys received through any grants and any premiums shall be credited to the medicaid buy-in cash fund, which fund is hereby created in the state treasury. Moneys in the fund shall be appropriated by the general assembly and expended by the state department for the purpose of conducting implementation activities as determined by the state department, including conducting the actuarial study. Premiums shall be credited to the fund for the purpose of offsetting program costs.

(c) Within three years after implementation of the medicaid buy-in program pursuant to this part 14, the state department shall submit a report on the effectiveness of the program to the health and human services committees of the general assembly, or any successor committees, and the joint budget committee of the general assembly.

(4) **Private health insurance.** (a) The state department shall, on behalf of an individual who is eligible for medicaid under subsection (1) of this section, pay premiums for or purchase individual coverage offered by the individual's employer if the state department determines that paying the premiums or purchasing the coverage will be less than providing medicaid coverage. Any employer-sponsored health insurance plan shall be the primary payer, and any payments made under medicaid shall be secondary. In the event that the employer-sponsored health insurance plan provides benefits that are not equivalent to the benefits provided under medicaid, medicaid shall provide all additional benefits that are not provided by the employer-sponsored health insurance plan.

(b) If an individual is eligible for medicaid under subsection (1) of this section and the individual's employer would pay for all or a portion of the individual's private insurance, the state department may accept contributions from the individual's employer to offset part of the cost of providing services pursuant to this section.

(5) **Medicare.** If federal financial participation is available, subject to available appropriations, the state department may pay medicare part A and part B premiums for individuals who are eligible for medicare and for medicaid under subsection (1) of this section.

25.5-6-1405. Rule-making authority. (1) The state board shall promulgate rules necessary to implement and administer the medicaid buy-in program created in this part 14, including the establishment of appropriate premium and cost-sharing charges on a sliding-fee scale based on income. The premiums and cost-sharing charges shall be based upon an actuarial study of the disabled population in this state.

(2) Any rules adopted by the state board shall be consistent with the federal "Ticket to Work and Work Incentives Improvement Act of 1999", Pub.L. 106-170.

25.5-6-1406. Availability of federal financial assistance under medical

assistance. Notwithstanding any other provision of law, this part 14 shall be implemented only if, and to the extent that, the state department determines that federal financial participation is available under the medicaid program.

CHILDREN'S BASIC HEALTH PLAN

ARTICLE 8

Children's Basic Health Plan

25.5-8-101. Short title. This article shall be known and may be cited as the "Children's Basic Health Plan Act".

25.5-8-102. Legislative declaration. (1) The general assembly hereby finds and declares that a significant percentage of children are uninsured. This lack of health insurance coverage decreases children's access to preventive health care services, compromises the productivity of the state's future workforce, and results in avoidable expenditures for emergency and remedial health care. Health care providers, health care facilities, and all purchasers of health care, including the state, bear the costs of this uncompensated care.

(2) The general assembly further finds and declares that the coordination and consolidation of funding sources currently available to provide services to uninsured children such as the Colorado indigent care program pursuant to part 1 of article 3 of this title, the children's basic health plan, and other children's health programs would efficiently and effectively meet the health care needs of uninsured children and would help to reduce the volume of uncompensated care in the state.

(3) (a) It is the intent of the general assembly to make health insurance coverage available and affordable and to support employers in their efforts to provide their employees and their dependents with health insurance coverage and to support increased availability of affordable health insurance in the individual market.

(b) It is the intent of the general assembly that the savings and efficiencies realized through actual reductions in administrative and programmatic costs associated with the implementation of this article and achieved in consolidating other health care programs should be identified.

(4) It is not the intent of the general assembly to create an entitlement for health insurance coverage.

(5) The general assembly hereby declares that the following principles shall be

used in implementing the children's basic health plan set forth in this article:

(a) The department shall establish and maintain a goal of inter-program communication in order to maximize existing state appropriations for the population served in the program;

(b) There shall be efficient program utilization through inter-program coordination and program consolidation and, where appropriate, through contracting with the private sector and with essential community providers;

(c) The policies enacted in House Bill 97-1304 regarding a strong managed care direction shall be emphasized;

(d) The private sector shall be involved to the greatest possible degree with respect to contracting for managed care;

(e) There shall be maximum emphasis on coordination with local and state public health programs and initiatives for children.

(6) The general assembly hereby finds and declares:

(a) That the goal of the "Children's Basic Health Plan Act" is to support low-income, working parents and families in overcoming barriers in obtaining good quality, affordable health care services for their children;

(b) That the health services that low-income children receive through the children's basic health plan should be cost-effective, of high quality, and promote positive health outcomes for enrolled children;

(c) That the children's basic health plan was designed as, and should continue to be, a private-public partnership that encourages enrollment and seeks every opportunity to operate with the efficiency and creativity that is found in utilizing private sector systems and business practices while maintaining the highest level of accountability to the general assembly, the executive branch, and the public through administration of the plan by the department;

(d) That the children's basic health plan was designed as, and should continue to be, a community-based program that encourages local participation in enrolling children in and supporting its goals.

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

(1) "Child" means a person who is less than nineteen years of age.

(2) "Children's basic health plan" or "plan" means the subsidized health insurance product designed by the department of health care policy and financing and provided to enrollees, as defined in this section.

(3) "Department" means the department of health care policy and financing created in section 25.5-1-104.

(4) "Eligible person" means:

(a) (I) A person who is less than nineteen years of age, whose family income does not exceed two hundred fifty percent of the federal poverty line, adjusted for family size.

(II) Notwithstanding the provisions of subparagraph (I) of this paragraph (a), if the moneys in the hospital provider fee cash fund established pursuant to section 25.5-4-402.3 (4), together with the corresponding federal matching funds, are insufficient to fully fund all of the purposes described in section 25.5-4-402.3 (4) (b), after receiving recommendations from the hospital provider fee oversight and advisory board established pursuant to section 25.5-4-402.3 (6), for persons less than nineteen years of age, the state board may by rule adopted pursuant to the provisions of section 25.5-4-402.3 (5) (b) (III) reduce the percentage of the federal poverty line to below two hundred fifty percent, but the percentage shall not be reduced to below two hundred five percent.

(III) (A) Notwithstanding the provisions of subparagraph (I) of this paragraph (a), until the state department receives federal authorization to increase the percentage of the federal poverty line for a person who is less than nineteen years of age, the percentage of the federal poverty line shall not exceed two hundred five percent.

(B) Within sixty days after the state department receives authorization to increase the percentage of the federal poverty line, the executive director shall send written notice to the revisor of statutes informing him or her of the authorization.

(C) This subparagraph (III) is repealed, effective the July 1 following the receipt of the notice to the revisor of statutes.

(b) (I) A pregnant woman whose family income does not exceed two hundred fifty percent of the federal poverty line, adjusted for family size, and who is not eligible for medicaid.

(II) Notwithstanding the provisions of subparagraph (I) of this paragraph (b), if the moneys in the hospital provider fee cash fund established pursuant to section 25.5-4-402.3 (4), together with the corresponding federal matching funds, are insufficient to fully fund all of the purposes described in section 25.5-4-402.3 (4) (b), after receiving recommendations from the hospital provider fee oversight and advisory board established pursuant to section 25.5-4-402.3 (6), for pregnant women, the state board by rule adopted pursuant to the provisions of section 25.5-4-402.3 (5) (b) (III) may reduce the percentage of the federal poverty line to below two hundred fifty percent, but the percentage shall not be reduced to below two hundred five percent.

(III) (A) Notwithstanding the provisions of subparagraph (I) of this paragraph (b), until the state department receives authorization to increase the percentage of the federal poverty line for a person who is less than nineteen years of age, the percentage of the federal poverty line shall not exceed two hundred five percent.

(B) Within sixty days after the state department receives authorization to increase the percentage of the federal poverty line, the executive director shall send written notice to the revisor of statutes informing him or her of the authorization.

(C) This subparagraph (III) is repealed, effective the July 1 following the receipt

of the notice to the revisor of statutes.

(5) "Enrollee" means any eligible person that has enrolled in the plan.

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

(a) Has historically served medically needy or medically indigent patients and demonstrates a commitment to serve low-income and medically indigent populations who make up a significant portion of its patient population, or in the case of a sole community provider, serves the medically indigent patients within its medical capability; and

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

(7) "Health care program" means any health care program in the state that is supported with state general fund or federal dollars.

(8) "Master settlement agreement" means the master settlement agreement, the smokeless tobacco master settlement agreement, and the consent decree approved and entered by the court in the case denominated *State of Colorado, ex rel. Gale A. Norton, Attorney General v. R.J. Reynolds Tobacco Co.; American Tobacco Co., Inc.; Brown & Williamson Tobacco Corp.; Liggett & Myers, Inc.; Lorillard Tobacco Co., Inc.; Philip Morris, Inc.; United States Tobacco Co.; B.A.T. Industries, P.L.C.; The Council For Tobacco Research--U.S.A., Inc.; and Tobacco Institute, Inc.*, Case No. 97 CV 3432, in the district court for the city and county of Denver.

(9) "Medical services board" means the medical services board created in section 25.5-1-301.

(10) "Subsidized enrollee" means an eligible person who receives a subsidy from the department to purchase coverage under the plan or a comparable health insurance.

(11) "Subsidy" means the amount paid by the department to assist an eligible person in purchasing coverage under the plan or a comparable health insurance product available to the eligible person through another coverage entity.

(12) "Trust" means the children's basic health plan trust created in section 25.5-8-105.

25.5-8-104. Children's basic health plan - rules. The medical services board is authorized to adopt rules to implement the children's basic health plan to provide health insurance coverage to eligible persons on a statewide basis pursuant to the provisions of this article. Any rules adopted by the children's basic health plan policy board in accordance with the requirements of the "State Administrative Procedure Act", article 4 of title 24, C.R.S., shall be enforceable and shall be valid until amended or repealed by the medical services board.

25.5-8-105. Trust - created. (1) A fund to be known as the children's basic

health plan trust is hereby created and established in the state treasury. Except as provided for in subsections (4) and (8) of this section, all moneys deposited in the trust and all interest earned on moneys in the trust shall remain in the trust for the purposes set forth in this article, and no part thereof shall be expended or appropriated for any other purpose. The principal of the trust shall be expended, subject to annual appropriation by the general assembly, solely for the purposes set forth in this article.

(2) (a) Except as provided for in subsections (4) and (8) of this section, all or a portion of the moneys in the trust shall be annually appropriated by the general assembly for the purposes of this article and shall not be transferred to or revert to the general fund of the state at the end of any fiscal year.

(b) Notwithstanding the provisions of paragraph (a) of this subsection (2), moneys in the trust may be used to pay the state's portion of any computer system changes necessary to expand eligibility in the plan.

(3) (a) Pursuant to section 24-75-1104.5 (1) (c), C.R.S., and except as otherwise provided in section 24-75-1104.5 (5), C.R.S., beginning in the 2006-07 fiscal year and in each fiscal year thereafter so long as the state receives moneys pursuant to the master settlement agreement, the state treasurer shall transfer to the trust twenty-four percent of the total amount of the moneys annually received by the state pursuant to the master settlement agreement, not including attorney fees and costs, during the preceding fiscal year; except that the amount so transferred to the trust shall not exceed thirty million dollars in any fiscal year. Except as otherwise provided in sections 24-22-115.5 (2) (a.7) and 24-75-1104.5 (1) (c), C.R.S., the state treasurer shall transfer the amount specified in this subsection (3) from moneys credited to the tobacco litigation settlement cash fund created in section 24-22-115, C.R.S. The amount transferred pursuant to this subsection (3) shall be in addition to and not in replacement of any general fund moneys appropriated to the trust.

(b) Pursuant to section 24-75-1104.5 (1.5) (a) (V), C.R.S., and except as otherwise provided in section 24-75-1104.5 (5), C.R.S., beginning in the 2007-08 fiscal year and each fiscal year thereafter so long as the state receives moneys pursuant to the master settlement agreement, the state treasurer shall transfer to the trust five percent of the portion of the moneys annually received by the state pursuant to the master settlement agreement, not including attorney fees and costs, during the preceding fiscal year that remains after the programs, services, and funds that receive such moneys pursuant to section 24-75-1104.5 (1), C.R.S., have been fully funded.

(4) On June 30, 2006, the state treasurer and the controller shall transfer eight million one hundred thousand dollars from the trust to the state general fund.

(5) (a) Beginning in fiscal year 1998, appropriations to the trust may be made by the general assembly based on the savings achieved through reforms, consolidations, and streamlining of health care programs realized through actual reductions in administrative and programmatic costs associated with the implementation of this article and not

decreases in the number of caseloads of such programs. Beginning with and subsequent to fiscal year 2000-01, the general assembly may make annual appropriations to the trust.

(b) (I) Notwithstanding any provision of paragraph (a) of this subsection (5) to the contrary, on March 27, 2002, the state treasurer shall deduct nine hundred thousand dollars from the trust and transfer such sum to the general fund.

(II) In order to restore the amount transferred from the trust pursuant to subparagraph (I) of this paragraph (b), moneys from the general fund shall be transferred to the trust in accordance with section 24-75-217, C.R.S.

(c) Notwithstanding any provision of this section to the contrary, on March 5, 2003, the state treasurer shall deduct from the trust, out of moneys appropriated pursuant to section 24-75-1104 (1) (b) (II), C.R.S., two million one thousand one hundred twenty-five dollars, and transfer such sum to the general fund.

(6) As part of its annual savings report to the general assembly on November 1 of each year, the department may identify efficiencies and consolidations that produce savings in the department's annual budget request that result in actual reductions in administrative and programmatic costs associated with the implementation of this article and not decreases in the number of caseloads of such programs. These identified savings shall not duplicate the savings reported in the annual savings report described in section 25.5-8-106.

(7) The department may receive payment for coverage offered and may receive or contract for donations, gifts, and grants from any source. Such funds shall be transmitted to the state treasurer who shall credit the same to the trust. The department may expend such funds from the trust for the purposes of this article.

(8) Beginning in the 2011-2012 fiscal year and for each fiscal year thereafter, moneys in the trust may be used for costs associated with children enrolled in the medical assistance program, articles 4, 5, and 6 of this title, whose family income is more than one hundred percent but does not exceed one hundred thirty-three percent of the federal poverty line and who would have been eligible for enrollment in the children's basic health plan prior to September 1, 2011.

25.5-8-106. Annual savings report. (1) By October 1 of each year, the department shall submit to the joint budget committee of the general assembly, to the health and human services committees of the house of representatives and the senate, or any successor committees, and to the office of state planning and budgeting an annual savings report stating the cost-savings anticipated in the previous, current, and subsequent fiscal years from health care program reforms, consolidations, and streamlining.

(2) The annual savings report shall include a description of net savings factoring in increased administrative expenses from the following:

(a) **Enrollment of medicaid clients in medicaid managed care programs.** In

calculating savings from enrollment of medicaid clients into medicaid managed care programs, the department shall calculate the total annual savings from growth in managed care enrollment subsequent to June 30, 1997.

(b) **Consolidation of the children's portions of the Colorado indigent care program into the plan.** In calculating the savings accrued and anticipated from consolidation of the children's portions of the Colorado indigent care program, created in part 1 of article 3 of this title, into the plan, the department shall use the following methodology: Estimate the reduction in expenditures due to the reduction in the number of children under age nineteen served by the Colorado indigent care program for each fiscal year in which children have been enrolled in the children's basic health plan.

(3) As reported in the annual savings report, the total savings from consolidation of the children's portions of the Colorado indigent care program, created in part 1 of article 3 of this title, into the plan shall not reduce the reimbursement rate of expenditures made on behalf of children to the Colorado indigent care program enrolled providers below the reimbursement rates used in the fiscal year prior to the first child enrolling in the plan.

(4) The department shall modify total savings calculated in paragraph (b) of subsection (2) of this section according to the geographic residence of subsidized enrollees and to the probable location of their health care providers under the Colorado indigent care program, created in part 1 of article 3 of this title.

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, the department shall have the following duties:

(a) (I) To design, and from time to time revise, a schedule of health care services included in the plan and to propose said schedule to the medical services board for approval or modification. The schedule of health care services as proposed by the department and approved by the medical services board shall include, but shall not be limited to, preventive care, physician services, prenatal care and postpartum care, inpatient and outpatient hospital services, prescription drugs and medications, and other services that may be medically necessary for the health of enrollees; except that the department may modify the schedule of health care services to meet specific federal requirements or to accommodate those changes necessary for a program designed specifically for children.

(II) In addition to the items specified in subparagraph (I) of this paragraph (a) and any additional items approved by the medical services board, on and after January 1, 2001, the medical services board shall include dental services in the schedule of health care services upon a finding by the board that:

(A) An adequate number of dentists are willing to provide services to eligible

children; and

(B) The financial resources available to the program are sufficient to fund such services.

(III) In addition to the items specified in subparagraphs (I) and (II) of this paragraph (a) 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 in the schedule of health care services.

(IV) The schedule of health care services included in the plan shall not include coverage pursuant to the mandatory coverage provisions of section 10-16-104 (1.4), C.R.S.

(b) To design and implement a system of cost-sharing with enrollees using an annual enrollment fee that is based on a sliding fee scale. The sliding fee scale shall be developed based on the enrollee's family income; except that no enrollment fee shall be assessed against an enrollee whose family income is at or below one hundred fifty percent of the federal poverty line and no enrollment fee shall be assessed against an enrollee who is a pregnant woman. As permitted by federal and state law, enrollees in the plan may use funds from a medical savings account to pay the annual enrollment fee. On or before November 1 of each year, the department shall submit for approval to the joint budget committee its annual proposal for cost sharing for the plan based upon a family's income.

(c) To design and implement a structure of copayments due to providers of managed health care plans from enrollees. Enrollees in the plan may use funds from a medical savings account to pay copayments.

(d) To design and propose to the medical services board for adoption detailed rules of eligibility and enrollment processes for the plan;

(e) To design a procedure whereby a financial sponsor may pay the annual enrollment fee or some portion thereof on behalf of a subsidized or nonsubsidized enrollee; except that the payment made on behalf of said enrollee shall not exceed the total enrollment fee due from the enrollee;

(f) To design a procedure whereby the plan may pay subsidies for eligible persons to purchase coverage under the plan or a comparable health insurance product;

(g) To establish criteria to allow a managed care plan, the department, or some other entity to verify eligibility pursuant to section 25.5-8-109;

(h) To conduct pilot projects including, but not limited to, testing models of marketing, enrollment, eligibility determination, and premium structures, to be implemented where appropriate and as approved by the joint budget committee.

(2) The department is authorized to institute a program for competitive bidding pursuant to section 24-103-202 or 24-103-203, C.R.S., for providing medical services on a managed care basis for children under this article. The department shall select more than one managed care contractor to serve counties in which there are providers

contracting with more than one managed care plan. In counties where there is only one operational managed care plan, the department may contract with that managed care plan to serve children enrolled in the plan. The department shall assure the utilization of essential community providers for the provision of services including eligibility determination, enrollment, and outreach when reasonable. The department shall contract with managed care organizations for the delivery of health services pursuant to this article. The department may contract with essential community providers for health care services in areas of the state that are not adequately served by managed care organizations.

(3) The department may contract for billing and premium collection functions for the children's basic health plan with vendors who provide billing and premium collection functions for other state insurance programs in order to consolidate billing and premium collection functions among multiple state programs. Such contracts may be entered into if the department determines that the scope of work provided by the vendor is similar to the work requirements for the children's basic health plan and that it would be more efficient and cost-effective to contract with the same vendor on multiple programs.

(4) Commencing with fiscal year 2001-02, the annual administrative costs for the children's basic health plan shall not exceed ten percent of the total annual program costs.

(5) The department may purchase vaccines recommended by the advisory committee on immunization practices to the centers for disease control and prevention in the federal department of health and human services, or its successor entity, through a vaccine purchasing system, if such a system is developed pursuant to section 25-4-2403 (1), C.R.S., for children enrolled in the children's basic health plan.

25.5-8-108. Financial management - cash system of accounting. (1) The department shall propose rules for approval by the medical services board to implement financial management of the plan. Pursuant to such rules, the department shall adjust benefit levels, eligibility guidelines, and any other measure to ensure that sufficient funds are present to implement the provisions of this article. The department shall develop and use quality assurance measures, such as the health employer data information set (HEDIS) reports regarding provider compensation, adapted to children's needs, to ensure that appropriate health care outcomes are met and to justify the continued use of taxpayer dollars for the plan. The department shall implement performance-based contracting based on such quality assurance measures.

(2) The department shall make a quarterly assessment of the expected expenditures for the plan for the remainder of the current biennium and for the following biennium. The estimated expenditures, including minimum reserve requirements shall be compared to an estimate of the revenues that will be deposited in the trust fund. Based on this comparison, the department shall make adjustments as necessary to ensure that

expenditures remain within the limits of available revenues for the remainder of the current biennium and the following biennium.

(3) The department may, in addition to any other measure it determines to be necessary, decrease subsidies for annual enrollment fees or limit enrollment in the plan to ensure that the trust retains sufficient funds pursuant to subsection (1) of this section.

(4) (a) Nothing in this article or any rules promulgated pursuant to the plan shall be interpreted to create a legal entitlement in any person to coverage under the plan. If enrollment in the plan is limited, the department shall give priority to children with family incomes under one hundred thirty-three percent of the federal poverty line.

(b) The department shall report quarterly to the joint budget committee on any enrollment caps that have been instituted for the plan and the number of children who are on waiting lists.

(5) The department shall utilize the cash system of accounting, as enunciated by the governmental accounting standards board, regardless of the source of revenues involved, for all activities of the department relating to the financial administration of any nonadministrative expenditure for the plan.

25.5-8-109. Eligibility - children - pregnant women. (1) To be eligible for a subsidy, a child must not be insured by a comparable health plan through an employer.

(2) If one child from a family is enrolled in the plan, all children must be enrolled, unless the other children have alternative health insurance coverage.

(3) The department may establish procedures such that children with family incomes that exceed the percent of the federal poverty guidelines specified in section 25.5-8-103 (4) (a) may enroll in the plan, but are not eligible for subsidies from the department.

(4) A child whose family income does not exceed the applicable level specified in section 25.5-8-103 (4) (a) shall be presumptively eligible for the plan. Children who are determined to be eligible for the plan shall remain eligible for twelve months subsequent to the last day of the month in which they were enrolled; except that a child shall no longer be eligible for the plan and shall be disenrolled from the plan if the department becomes aware of or is notified that any of the following has occurred:

(a) The child has moved out of the state;

(b) The child has been enrolled in the medicaid program; except that, in disenrolling a child pursuant to this paragraph (b), the department shall ensure that the child is continuously covered under this section until the coverage is attained under the medicaid program and that there is no gap in coverage; or

(c) The child has been enrolled in a commercial health insurance plan during the twelve-month period following enrollment in the plan under this article.

(4.5) (a) (I) To the extent authorized by federal law, the department shall require

an applicant to state only the applicant's family income and shall notify the applicant that the applicant's family income will be verified by the department through the most recently available records of the division of unemployment insurance in the department of labor and employment or through the income, eligibility, and verification system. The department shall allow an applicant to provide income information more recent than the records of the division of unemployment insurance or the income, eligibility, and verification system.

(II) The department shall annually verify the recipient's income eligibility at reenrollment through the records of the division of unemployment insurance in the department of labor and employment or through the income, eligibility, and verification system. If a recipient meets all eligibility requirements, a recipient remains enrolled in the plan. The department shall also allow a recipient to provide income information more recent than the records of the division of unemployment insurance or the income, eligibility, and verification system.

(III) If the state department determines that a recipient was not eligible for medical benefits solely based upon the recipient's income after the recipient had been determined to be eligible based upon the records of the division of unemployment insurance or the income, eligibility, and verification system, the state department shall not pursue recovery from a county department for the cost of medical services provided to the recipient, and the county department is not responsible for any federal error rate sanctions resulting from such determination.

(IV) Notwithstanding any other provision in this paragraph (a), for applications that contain self-employment income, the state department shall not implement this paragraph (a) until it can verify self-employment income through the income, eligibility, and verification system or other verification as authorized by rules of the state department and federal law.

(b) Repealed.

(c) Subject to the provisions and requirements of section 25.5-4-205 (3) (e), the department shall establish a process so that an enrollee or the parent or guardian of an enrollee may apply for reenrollment either over the telephone or through the internet.

(5) (a) (I) A pregnant woman whose family income does not exceed the applicable level specified in section 25.5-8-103 (4) (b) shall be presumptively eligible for the plan. Once determined eligible for the plan, a pregnant woman shall be considered to be continuously eligible throughout the pregnancy and for the sixty days following the pregnancy, even if the woman's eligibility would otherwise terminate during such period due to an increase in income. Upon birth, a child born to a woman eligible for the plan shall be eligible for the plan and shall be automatically enrolled in the plan in accordance with the eligibility requirements for children specified in subsection (4) of this section.

(II) Repealed.

(b) (I) Under the plan, prenatal and postpartum primary health care providers shall

implement policies regarding the integration of evidence-based tobacco use treatments into the regular health care delivery system, including, but not limited to:

- (A) Assessment of tobacco use and exposure to second-hand smoke;
- (B) Education on the dangers of tobacco use during pregnancy and postpartum;
- (C) Referrals to appropriate cessation services.

(II) Health care providers may coordinate the implementation of such policies with the tobacco education, prevention, and cessation programs established in section 25-3.5-804, C.R.S.

(c) The addition of coverage under the plan for pregnant women shall only be implemented if the department obtains a waiver from the federal department of health and human services.

(d) Enrollment of a pregnant woman in the plan shall be limited based upon annual appropriations made out of the trust by the general assembly as described in section 25.5-8-105 and any grants and donations. The general assembly shall annually establish maximum enrollment figures for pregnant women in the plan. The department shall not exceed the enrollment caps regardless of whether the funding comes from annual appropriations or grants and donations.

(6) Notwithstanding any other provision of law, but subject to the availability of sufficient appropriations and the receipt of federal financial participation, the department may provide benefits under this article to a pregnant woman who is a qualified alien and a child under nineteen years of age who is a qualified alien so long as such woman or child meets eligibility criteria other than citizenship.

25.5-8-110. Participation by managed care plans. (1) Managed care plans, as defined in section 10-16-102 (43), C.R.S., that participate in the plan shall do so by contract with the department and shall provide the health care services covered by the plan to each enrollee.

(2) Managed care plans participating in the plan shall not discriminate against any potential or current enrollee based upon health status, disability, sex, sexual orientation, marital status, race, creed, color, national origin, ancestry, ethnicity, or religion.

(3) Managed care plans that contract with the department to provide the plan to enrollees shall also be willing to contract with the medicaid managed care program, as administered by the department.

(4) (a) Managed care plans shall be selected by the department to participate in the children's basic health plan based upon the managed care plans' assurances and the department's verification that the managed care plan is utilizing within its network essential community providers to the extent that this action does not result in a net increase in the cost for providing services to the managed care plan.

(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 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 proposals in good faith and shall, when deemed reasonable by the managed care organization based on the needs of its enrollees, contract with essential community providers. Each essential community provider shall be willing to negotiate on reasonably equitable terms with each managed care organization. Essential community providers making proposals under this subsection (4) shall be able to meet the contractual requirements of the managed care organization. The requirement of this subsection (4) shall not apply to a managed care organization in areas in which the managed care organization operates entirely as a group model health maintenance organization.

(c) Any disputes between a managed care organization and an essential community provider that cannot be resolved through good faith negotiations may be resolved through an informal review by the department at the request of one of the parties, or through the department's aggrieved provider appeal process in accordance with section 25.5-1-107 (2), if requested by one of the parties.

(d) In selecting managed care organizations through competitive bidding, the department shall give preference to those managed care organizations that have executed contracts for services with one or more essential community providers. In selecting managed care organizations, the department shall not penalize a managed care organization for paying cost-based reimbursement to federally qualified health centers as defined in the federal "Social Security Act".

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

(6) Parents or guardians of children shall choose a participating health maintenance organization before enrolling in the plan in areas of the state where a participating health maintenance organization is available. The department will assign children who are currently enrolled in the plan and whose parents or guardians have not selected a health maintenance organization within a time period determined by the department to a participating health maintenance organization with the child's primary care physician in the network. The department shall seek to maintain continuity of the health plan between medicaid and the children's basic health plan.

(7) In areas of the state in which a participating managed care plan does not have providers, the department may contract with essential community providers and other health care providers to provide health care services under the children's basic health plan using a managed care model.

(8) The department may contract with essential community providers or other providers or develop other administrative arrangements to provide health care services under the children's basic health plan to enrollees prior to the effective date of enrollment in the selected managed care plan.

(9) The department shall allow, at least annually, an opportunity for enrollees 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 opportunity is afforded eligible recipients. In geographic regions served by more than one participating managed care plan, the department shall endeavor to establish a uniform period for such opportunity.

(10) (a) The department shall make a capitation payment to managed care plans based upon a defined scope of services at an agreed upon rate. The department shall only use market rate bids that do not discriminate and are adequate to assure quality, network sufficiency, and long-term competitiveness in the children's basic health plan managed care market. The department shall retain a qualified actuary to establish a lower limit for such bids. A certification by such actuary to the appropriate lower limit shall be conclusive evidence of the department's compliance with the requirements of this subsection (10). For the purposes of this subsection (10), a "qualified actuary" shall be a person deemed as such under rules promulgated by the commissioner of insurance.

(b) Repealed.

(11) All managed care plans participating in the plan shall meet standards regarding the quality of services to be provided, financial integrity, and responsiveness to the unmet health care needs of eligible persons that may be served.

25.5-8-111. Department - administration - outsourcing. (1) (a) The department may:

(I) Pursuant to section 24-50-504 (2) (a), C.R.S., enter into personal services contracts for the administration of the children's basic health plan. Any contracts established pursuant to this section shall contain performance measures that shall be monitored by the department.

(II) Use county departments of social services to perform functions relating to the administration of the children's basic health plan;

(III) Perform administrative functions at the department, including consolidation of functions with other administrative functions handled by the department.

(b) In deciding how to allocate functions relating to the administration of the children's basic health plan as allowed under paragraph (a) of this subsection (1), the department shall determine and base its decisions upon what is the most cost-effective method to handle the particular function and to deliver the services.

(2) The implementation of subparagraph (I) of paragraph (a) of subsection (1) of

this section is contingent upon a finding by the state personnel director that any of the conditions of section 24-50-504 (2), C.R.S., have been met or that the conditions of section 24-50-503 (1), C.R.S., have been met.

25.5-8-112. Authority to the department to apply for federal waivers. The department is hereby authorized and required to apply for any federal waivers necessary to implement the purposes of this article.

25.5-8-113. Reports by contractors to medical services board. Any personal services contractor that contracts with the department to provide services under this article shall provide quarterly reports to the medical services board relating to the functions performed by the contractor, including reports on enrollment, utilization, marketing, and any concerns or recommendations relating to improving the administration of or the quality of the program. In addition, any contractor shall submit any data requested by the medical services board relating to the children's basic health plan and the functions provided by that contractor.

ARTICLE 10

Community Living

PART 1

OFFICE OF COMMUNITY LIVING

25.5-10-101. Office of community living - creation - transfer of duties and functions - rules - legislative declaration - repeal. (1) There is hereby created in the state department the office of community living, referred to in this article as the "office". The head of the office is the director of community living appointed by the executive director in accordance with section 13 of article XII of the state constitution. The director of community living reports directly to the executive director.

(2) (a) On and after March 1, 2014, the powers, duties, and functions relating to the programs, services, and supports contained in this article are transferred from the department of human services to the department of health care policy and financing by a type 2 transfer as such transfer is defined in the "Administrative Organization Act of 1968", article 1 of title 24, C.R.S., and allocated to the division of intellectual and

developmental disabilities of the office, which division is created in part 2 of this article.

(b) (I) By March 1, 2014, all positions of employment in the department of human services related to the administration of community-based long-term services and supports are transferred to the division of intellectual and developmental disabilities of the office and become employment positions therein.

(II) All employees in positions transferred to the division of intellectual and developmental disabilities are considered employees of the division of intellectual and developmental disabilities of the office. Such employees retain all rights under the state personnel system and to retirement benefits pursuant to the laws of this state, and their services shall be deemed to have been continuous.

(c) By March 1, 2014, all items of property, real and personal, including office furniture and fixtures, books, documents, and records of the department of human services related to the administration of community-based long-term services and supports are transferred to the division of intellectual and developmental disabilities of the office and become the property thereof.

(d) On and after March 1, 2014, whenever the executive director of the department of human services or the department of human services is referred to or designated by any contract or other document in connection with the powers, duties, and functions transferred to the department of health care policy and financing, the reference or designation shall be deemed to apply to the department of health care policy and financing. All contracts entered into by the executive director of the department of human services prior to March 1, 2014, in connection with the powers, duties, and functions transferred to the department of health care policy and financing are hereby validated, with the executive director of the department of health care policy and financing succeeding to all the rights and obligations of such contracts.

(3) All rules and orders of the department of human services, the executive director of the department of human services, and the state board of human services in connection with the programs transferred to the department of health care policy and financing shall continue to be effective until revised, amended, repealed, or nullified pursuant to law.

(4) (a) The state department shall report to the joint budget committee of the general assembly during a meeting of the joint budget committee in September and November 2013, in conjunction with a representative of the community-centered boards, a representative of service providers, and a representative of a statewide organization advocating and providing support for children and adults with intellectual and developmental disabilities concerning the creation of the office and any issues relating to the transfer of powers, duties, and functions to the state department pursuant to this part 1.

(b) This subsection (4) is repealed, effective July 1, 2014.

PART 2

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

25.5-10-201. Legislative declaration. (1) In recognition of the varied, extensive, and substantial needs of persons with intellectual and developmental disabilities, including the urgent need to enhance the development of children with intellectual and developmental disabilities, the general assembly, subject to available appropriations and subject to the existence of appropriate services and supports with available resources, hereby declares that the purposes of this article are:

(a) To provide appropriate services and supports to persons with intellectual and developmental disabilities throughout their lifetimes regardless of their age or degree of disability;

(b) To prohibit deprivation of liberty of persons with intellectual and developmental disabilities, except when such deprivation is for the purpose of providing services and supports which constitute the least restrictive available alternative adequate to meet the person's needs, and to ensure that these services and supports afford due process protections;

(c) To ensure the fullest measure of privacy, dignity, rights, and privileges to persons with intellectual and developmental disabilities;

(d) To ensure the provision of services and supports to all persons with intellectual and developmental disabilities on a statewide basis;

(e) To enable persons with intellectual and developmental disabilities to remain with their families and in the community of their choice, to minimize the likelihood of out-of-home placement, and to enhance the capacity of families to meet the needs of children with intellectual and developmental disabilities;

(f) To provide community services and supports for persons with intellectual and developmental disabilities which reflect typical patterns of everyday living;

(g) To encourage state and local agencies to provide a wide array of innovative and cost-effective services and supports for persons with intellectual and developmental disabilities;

(h) To ensure that persons with intellectual and developmental disabilities receive services and supports which encourage and build on existing social networks and natural sources of support, and result in increased interdependence, contribution to, and inclusion in community life; and

(i) To recognize the efficacy of early intervention services and supports in minimizing developmental delays and reducing the future education costs to our society.

Editor's note: This section is effective March 1, 2014.

25.5-10-202. Definitions. As used in this article, unless the context otherwise requires:

(1) "Authorized representative" means a person designated by the person receiving services, or by the parent or guardian of the person receiving services, if appropriate, to assist the person receiving services in acquiring or utilizing services or supports pursuant to this article. The extent of the authorized representative's involvement shall be determined upon designation.

(2) "Case management services" means the following:

(a) The determination of eligibility for services and supports;

(b) Service and support coordination; and

(c) The monitoring of all services and supports delivered pursuant to the individualized plan and the evaluation of results identified in the individualized plan.

(3) "Case manager" means a person who assists with case management services and supports provided pursuant to this article for persons with intellectual and developmental disabilities.

(4) "Community-centered board" means a private corporation, for-profit or not-for-profit, that, when designated pursuant to section 25.5-10-208, provides case management services to persons with intellectual and developmental disabilities, is authorized to determine eligibility of those persons within a specified geographical area, serves as the single point of entry for persons to receive services and supports under this article, and provides authorized services and supports to those persons either directly or by purchasing services and supports from service agencies.

(5) "Community residential home" means a group living situation accommodating at least four but no more than eight persons, which is licensed by the state and in which services and supports are provided to persons with intellectual and developmental disabilities.

(6) "Consent" means an informed assent that is expressed in writing and freely given. Consent shall always be preceded by the following:

(a) A fair explanation of the procedures to be followed, including an identification of procedures that are experimental;

(b) A description of the attendant discomforts and risks;

(c) A description of the expected benefits;

(d) A disclosure of appropriate alternative procedures together with an explanation of the respective benefits, discomforts, and risks;

(e) An offer to answer any inquiries concerning procedures;

(f) An instruction that the person giving consent is free to withdraw consent and to discontinue participation in the project or activity at any time; and

(g) A statement that withholding or withdrawal of consent shall not prejudice

future provision of appropriate services and supports to persons.

(7) "Contribution" means the benefits gained by the household or community in which a person lives as the result of the person engaging in meaningful activities, including but not limited to income-producing work, volunteer work, continuing education, and participation in community activities.

(8) "Court" means a district court of the state of Colorado or the probate court in the appropriate jurisdiction.

(9) "Designated service area" means the geographical area specified by the executive director to be served by a designated community-centered board.

(10) "Developmental disabilities professional" has the same meaning as "intellectual and developmental disabilities professional" as set forth in subsection (25) of this section.

(11) (a) "Developmental disability" has the same meaning as "intellectual and developmental disability" as set forth in paragraph (a) of subsection (26) of this section.

(b) "Person with a developmental disability" or "individual with a developmental disability" has the same meaning as "person with an intellectual and developmental disability" as set forth in paragraph (b) of subsection (26) of this section.

(c) "Child with a developmental delay" has the same meaning as set forth in paragraph (c) of subsection (26) of this section.

(12) "Division" means the division of intellectual and developmental disabilities, created in this part 2.

(13) "Early intervention services and supports" has the same meaning as set forth in section 27-10.5-102, C.R.S.

(14) "Eligible for supports and services" refers to any person with an intellectual and developmental disability as determined eligible by the community-centered boards, pursuant to section 25.5-10-210.

(15) "Enrolled" means that a person with an intellectual and developmental disability who is eligible for supports and services has been authorized, as defined by rules promulgated by the state board, to participate in the program funded pursuant to this section.

(16) (a) "Family" means the interdependent group of persons that consists of:

(I) A parent, child, sibling, grandparent, aunt, uncle, spouse, or any combination thereof and a family member with an intellectual and developmental disability;

(II) An adoptive parent of and a family member with an intellectual and developmental disability;

(III) One or more persons to whom legal custody of a person with an intellectual and developmental disability has been given by a court and in whose home such person resides; or

(IV) Any other family unit as may be defined in rules developed pursuant to section 25.5-10-306.

(b) State board rules must define the families that are eligible to receive services and supports pursuant to this article, and rules of the state board of human services must define the families that are eligible to receive services and supports pursuant to article 10.5 of title 27, C.R.S.

(17) "Family caregiver" means a family member of the person with an intellectual and developmental disability who provides care to the person with an intellectual and developmental disability in the family home, who meets the requirements for a qualified family caregiver, as established by rule of the state board, and who is working through a program-approved service agency, as established by rule of the state board.

(18) "Gastrostomy tube" means a tube that has been surgically inserted into the stomach through the abdominal wall, or a tube that has been inserted through the nasal passage into the stomach, or both.

(19) "Human rights committee" means a third-party mechanism to adequately safeguard the legal rights of persons receiving services by participating in the granting of informed consent, monitoring the suspension of rights of persons receiving services, monitoring behavioral development programs in which persons with intellectual and developmental disabilities are involved, monitoring the use of psychotropic medication by persons with intellectual and developmental disabilities, and, at the committee's option, either providing or ensuring the investigation of allegations of abuse or neglect of persons with intellectual and developmental disabilities who are receiving services or supports under this article.

(20) "IDEA" has the same meaning as set forth in section 27-10.5-102, C.R.S.

(21) "Inclusion" means:

(a) The use by persons with intellectual and developmental disabilities of the same community resources that are used by and available to other persons;

(b) The participation by persons with intellectual and developmental disabilities in the same community activities in which persons without intellectual and developmental disabilities participate. Participation includes regular contact with persons without intellectual and developmental disabilities.

(c) Vocational experiences for persons with intellectual and developmental disabilities in community settings that offer opportunities to associate with other persons who do not have intellectual and developmental disabilities; and

(d) Living in homes that are in residential neighborhoods and in proximity to community resources.

(22) "Independent residential support services" means a community living situation, defined by rule of the state board, in which services and supports are provided to no more than three persons with intellectual and developmental disabilities and for which a state license is not required.

(23) "Individualized family service plan" or "IFSP" has the same meaning as set forth in section 27-10.5-102, C.R.S.

(24) (a) "Individualized plan" means a written plan designed by an interdisciplinary team for the purpose of identifying:

- (I) The needs and preferences of the person or family receiving services;
- (II) The specific services and supports appropriate to meet those needs and preferences;
- (III) The projected date for initiation of services and supports; and
- (IV) The anticipated results to be achieved by receiving the services and supports.

(b) Every individualized plan must include a statement of agreement with the plan, signed by the person receiving services or other such person legally authorized to sign on behalf of the person and by a representative of the community-centered board.

(c) Any other service or support plan designated by the state department that meets all of the requirements of an individualized plan is considered to be an individualized plan pursuant to this article.

(d) (I) Every individualized plan that includes the provision of respite care for medical purposes, pursuant to section 25.5-10-205, shall include a process by which the person receiving services and supports may receive necessary care if the person's family or caregiver is unavailable due to an emergency situation or unforeseen circumstances. The family or caregiver must be duly informed by the interdisciplinary team of these alternative care provisions at the time the individualized plan is initiated.

(II) Nothing in this paragraph (d) requires the provision of respite care. However, any individual plan that includes the provision of respite care for medical purposes must contain a contingency plan.

(25) "Intellectual and developmental disabilities professional" means a person who has professional training and experience in the intellectual and developmental disabilities field, as defined by rule of the state board.

(26) (a) "Intellectual and developmental disability" means a disability that manifests before the person reaches twenty-two years of age, that constitutes a substantial disability to the affected person, and that is attributable to mental retardation or related conditions, which include cerebral palsy, epilepsy, autism, or other neurological conditions when those conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation. Unless otherwise specifically stated, the federal definition of "developmental disability" found in 42 U.S.C. sec. 15001 et seq. shall not apply.

(b) "Person with an intellectual and developmental disability" means a person determined by a community-centered board to have an intellectual and developmental disability and shall include a child with a developmental delay.

(c) "Child with a developmental delay" means:

(I) A person less than five years of age with delayed development as defined by rule of the state board; or

(II) A person less than five years of age who is at risk of having a developmental

disability as defined by rule of the state board.

(27) "Interdependence" means those multiple interactive relationships that are necessary to create a sense of belonging and support between and among people that are mutually sought, sustained over time, and beneficial to those involved.

(28) "Interdisciplinary team" means a group of people convened by a designated community-centered board that includes the person receiving services; the parents or guardian of a minor; a guardian or an authorized representative, as appropriate; the person who coordinates the provisions of services and supports; and others as determined by the person's needs and preference, who are assembled to work in a cooperative manner to develop or review the individualized plan.

(29) "Least restrictive environment" means an environment that represents the least departure from the typical patterns of living and that effectively meets the needs and preferences of the person receiving services. "Least restrictive environment" may include, but need not be limited to, receiving services from a community-centered board, service agency, or a family caregiver in the family home.

(30) "Office" means the office of community living created in part 1 of this article.

(31) "Person receiving services" means a person with an intellectual and developmental disability who is enrolled in a program funded pursuant to this article.

(32) "Program" means a specific group of services or supports as defined by rules promulgated by the state board and for which funding is available pursuant to this article to a person with an intellectual and developmental disability who is eligible for supports and services.

(33) "Regional center" has the same meaning as set forth in section 27-10.5-102, C.R.S.

(34) "Service agency" means a person or any publicly or privately operated program, organization, or business providing services or supports for persons with intellectual and developmental disabilities.

(35) "Service and support coordination" means planning, locating, facilitating access to, coordinating, and reviewing all aspects of needed services, supports, and resources that are provided in cooperation with the person receiving services, the person's family, as appropriate, the family of a child with a developmental delay, and the involved public or private agencies. Planning includes the development or review of an existing individualized plan. "Service and support coordination" also includes the reassessment of the needs and preferences of the person receiving services or the needs of the family of the person, with maximum participation of the person receiving services and the person's parents, guardian, or authorized representative, as appropriate.

(36) "Services and supports" means one or more of the following: Education, training, independent or supported living assistance, therapies, identification of natural supports, and other activities provided:

(a) To enable persons with intellectual and developmental disabilities to make responsible choices, exert greater control over their lives, experience presence and inclusion in their communities, develop their competencies and talents, maintain relationships, foster a sense of belonging, and experience personal security and self-respect;

(b) To enhance child development and healthy parent-child and family interaction for eligible persons and their families; and

(c) To enable families, who choose or desire to maintain a family member with an intellectual and developmental disability at home, to obtain support and to enjoy a typical lifestyle.

(37) "Sterilization" means any surgical or other medical procedure that has as its primary purpose to render a person permanently incapable of reproduction.

(38) "Waiting list" means the list of persons with intellectual and developmental disabilities who are waiting for enrollment into a program provided pursuant to this article.

Editor's note: This section is effective March 1, 2014.

25.5-10-203. Division of intellectual and developmental disabilities - creation - functions - reporting - legislative declaration - repeal. (1) (a) The general assembly finds and declares that:

(I) An effective system of community-based services and supports is essential to enable children and adults with intellectual and developmental disabilities to live in their communities;

(II) The demand for high-quality intellectual and developmental disabilities services is expected to grow; and

(III) Persons with intellectual and developmental disabilities need a system that promotes self-direction of services and self-determination and that is designed to improve personal outcomes.

(b) (I) The general assembly further finds and declares that state agencies should be organized in a manner that allows for improved delivery of long-term services and supports for persons and providers; and

(II) The transfer pursuant to part 1 of this article of the powers, duties, and functions relating to the programs, services, and supports for persons with intellectual and developmental disabilities to the office for administration by the division of intellectual and developmental disabilities, created in this section, is an initial step in the process of redesigning Colorado's long-term care system.

(2) There is hereby created within the office the division of intellectual and

developmental disabilities.

(3) The division shall administer the programs, services, and supports for persons with intellectual and developmental disabilities contained in this article.

(4) Because of the unique goal of the division in administering lifelong programs, services, and supports for persons with intellectual and developmental disabilities, as part of its annual briefing to the joint budget committee, the state department shall allow sufficient briefing time devoted solely to issues relating to the division and its administration of the programs, services, and supports contained in this article.

(5) (a) The state department, in conjunction with a representative of the community-centered boards, a representative of service providers, and a representative of a statewide organization advocating and providing support for children and adults with intellectual and developmental disabilities, shall report concerning the operational status of the division and any unresolved issues relating to the transfer of powers, duties, and functions to the state department pursuant to part 1 of this article. The report shall be made quarterly to the joint budget committee of the general assembly and to 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, commencing in March 2014 and concluding in December 2014.

(b) This subsection (5) is repealed, effective July 1, 2015.

Editor's note: This section is effective March 1, 2014.

25.5-10-204. Duties of the executive director - state board rules. (1) In order to implement the provisions of this article, the executive director shall, subject to available appropriations, carry out the following duties:

(a) Conduct monitoring and review activities that include community-centered boards and service agencies;

(b) Provide or obtain training and technical assistance through community-centered boards and service agencies in order to improve the quality of services and supports provided to persons with intellectual and developmental disabilities;

(c) Prepare and transmit annually to the governor and the joint budget committee of the general assembly, in the form and manner prescribed pursuant to section 24-1-136, C.R.S., a report detailing the following information, as available and appropriate, that is broken down into designated service areas as well as provided in an overall statewide format:

(I) The total number of persons receiving services pursuant to this article;

(II) The types of services and supports provided;

(III) The costs of services and supports regardless of funding source;

- (IV) An evaluation of the quality of the services and supports rendered;
 - (V) An evaluation of the effectiveness of the services and supports rendered in implementing the individualized plans of persons receiving services;
 - (VI) The numbers, types, and resolution of appeals that were heard by the state department arising from disputes specified in section 25.5-10-212; and
 - (VII) The number of persons determined to be eligible to receive services and supports who are not receiving services or supports pursuant to this article along with an analysis of the reasons they are not receiving services and supports;
- (d) Designate a community-centered board in each designated service area in the state;
 - (e) Implement the provision of home- and community-based services to eligible persons with intellectual and developmental disabilities and pursue other medicaid-funded services determined by the state department to be appropriate for persons with intellectual and developmental disabilities, pursuant to part 4 of article 6 of this title and subject to available appropriations; and
 - (f) Promote effective coordination with agencies serving persons with intellectual and developmental disabilities in order to improve continuity of services and supports for persons facing life transitions from toddler to preschool, school to adult life, and work to retirement.
- (2) The state board shall adopt such rules, in accordance with section 24-4-103, C.R.S., as are necessary to carry out the provisions and purposes of this article, including but not limited to the following subjects:
 - (a) Standards for services and supports, including preparation of individualized plans;
 - (b) The designation of community-centered boards and the organization of those entities, including standards of organization, staff qualifications, and other factors necessary to ensure program integrity;
 - (c) Purchase of services and supports and financial administration;
 - (d) Procedures for resolving disputes over eligibility determination and the modification, denial, or termination of services;
 - (e) Eligibility determination, the criteria for determination, and admission to the program;
 - (f) Systems of quality assurance and data collection;
 - (g) The rights of a person receiving services;
 - (h) Confidentiality of records of a person receiving services;
 - (i) Designation of authorized representatives and delineation of their rights and duties pursuant to this article;
 - (j) (I) The establishment of guidelines and procedures for authorization of persons for administration of nutrition and fluids through gastrostomy tubes.
 - (II) The state department shall require that a service agency providing residential

or day program services or supports have a staff member qualified pursuant to subparagraph (III) of this paragraph (j) on duty at any time the facility administers said nutrition and fluids through gastrostomy tubes, and that the facility maintain a written record of each nutrient or fluid administered to each person receiving services, including the time and the amount of the nutrient or fluid.

(III) A person who is not otherwise authorized by law to administer nutrition and fluids through gastrostomy tubes is allowed to perform the duties only under the supervision of a licensed nurse or physician. A person who administers nutrition and fluids in compliance with the provisions of this paragraph (j) is exempt from the licensing requirements of the "Colorado Medical Practice Act", article 36 of title 12, C.R.S., and the "Nurse Practice Act", article 38 of title 12, C.R.S. Nothing in this paragraph (j) shall be deemed to authorize the administration of medications through gastrostomy tubes. A person administering medications through gastrostomy tubes is subject to the requirements of part 3 of article 1.5 of title 25, C.R.S.

(IV) For purposes of this paragraph (j), "administration" means assisting a person in the ingestion of nutrition or fluids according to the direction and supervision of a licensed nurse or physician.

Editor's note: This section is effective March 1, 2014.

25.5-10-205. Community-centered boards and service agencies - local public procurement units. For purposes of entering into a cooperative purchasing agreement pursuant to section 24-110-201, C.R.S., a nonprofit community-centered board or a nonprofit service agency may be certified as a local public procurement unit as provided in section 24-110-207.5, C.R.S.

Editor's note: This section is effective March 1, 2014.

25.5-10-206. Authorized services and supports - conditions of funding - purchase of services and supports - boards of county commissioners - appropriation. (1) Subject to annual appropriations by the general assembly, the state department shall provide or purchase, pursuant to subsection (4) of this section, authorized services and supports from community-centered boards or service agencies for persons who have been determined to be eligible for such services and supports pursuant to section 25.5-10-211 and as specified in the eligible person's individualized plan. Those services and supports may include, but need not be limited to, the following:

(a) Family support services, including an array of supportive services provided to the person receiving services and the person's family, that enable the family to maintain the person in the family home, thereby preventing or delaying the need for out-of-home placement that is unwanted by the person or the family, pursuant to section 25.5-10-301;

(b) Case management services;

(c) Respite care services, including temporary care of a person with an intellectual and developmental disability to offer relief to the person's family or caregiver or to allow the family or caregiver to deal with emergency situations or to engage in personal, social, or routine activities and tasks that otherwise may be neglected, postponed, or curtailed due to the demands of supporting a person who has an intellectual and developmental disability;

(d) Day services and supports that offer opportunities for persons with intellectual and developmental disabilities to experience and actively participate in valued adult roles in the community. These services and supports will enable persons receiving services to access and participate in community activities, such as work, recreation, higher education, and senior citizen activities. Day services may also include the administration of nutrition or fluids through gastrostomy tubes, if administered by a person authorized pursuant to section 25.5-10-204 (2) (j) and supervised by a licensed nurse or physician.

(e) Residential services and supports, including an array of training, learning, experiential, and support activities provided in living alternatives designed to meet the individual needs and preferences of persons receiving services and may include the administration of nutrition or fluids through gastrostomy tubes, if administered by a person authorized pursuant to section 25.5-10-204 (2) (j) and supervised by a licensed nurse or physician; and

(f) Ancillary services, including activities that are secondary but integral to the provision of the services and supports specified in this subsection (1).

(2) Service agencies receiving funds pursuant to subsection (1) of this section shall comply with all of the provisions of this article and the rules promulgated thereunder.

(3) Service and support coordination shall be purchased from the community-centered board designated pursuant to section 25.5-10-209 except as otherwise provided in subsection (4) of this section.

(4) (a) The state department may purchase services and supports, including service and support coordination, directly from service agencies if:

(I) Required by the federal requirements for the state to qualify for federal funds under Title XIX of the federal "Social Security Act", as amended, including programs authorized pursuant to part 4 of article 6 of this title; or

(II) The executive director has determined that a service or support provided or purchased by a designated community-centered board does not meet established standards and the continuation of purchase of the service or support through the community-

centered board is not in the best interests of the persons receiving services.

(b) The state department shall only purchase services and supports directly from those community-centered boards or service agencies that meet established standards.

(c) The state department may purchase services and supports, including service and support coordination, from a family caregiver if the executive director has determined that the provision of a service or support by a family caregiver in the family home would provide the person receiving the service or support with the least restrictive environment.

(d) Nothing in this section shall be construed to prohibit the provision of services and supports, including case management services, directly by the department of human services through regional centers, for persons receiving services in regional centers.

(e) Nothing in this section shall be construed to require the provision of services and supports, including case management services, directly by the state department.

(5) Governmental units, including but not limited to counties, municipalities, school districts, health service districts, and state institutions of higher education, are authorized at their own expense to furnish money, materials, or services and supports to persons with intellectual and developmental disabilities, or to purchase services and supports for such persons through designated community-centered boards or service agencies, so long as no conditions or requirements imposed as a result of the provision or purchase through a community-centered board or service agency conflict with the provisions of this article or the rules promulgated thereunder.

(6) Boards of county commissioners may levy up to one mill for the purpose of purchasing services and supports for persons with intellectual and developmental disabilities. To the extent authorized by federal law, and subject to annual appropriation by the general assembly, and pursuant to rules established by the state board, a county may transfer the revenue raised pursuant to the mill levy to the state department to receive matching federal funds to provide medicaid-approved waiver services to persons with intellectual and developmental disabilities.

(7) (a) Each year the general assembly shall appropriate moneys to the state department to provide or purchase services and supports for persons with intellectual and developmental disabilities pursuant to this section. Unless specifically provided otherwise, services and supports shall be purchased on the basis of state funding less any federal or cash funds received for general operating expenses from any other state or federal source, less funds available to a person receiving residential services or supports after such person receives an allowance for personal needs or for meeting other obligations imposed by federal or state law, and less the required local school district funds specified in paragraph (b) of this subsection (7). The yearly appropriation, when combined with all other sources of funds, shall in no case exceed one hundred percent of the approved program costs as determined by the general assembly.

(b) Each school district shall pay to the community-centered board providing programs attended by a student with an intellectual and developmental disability, who is

domiciled in the school district and may be counted in the district's pupil enrollment, an amount at least equal to the district's per pupil revenues as determined pursuant to the "Public School Finance Act of 1994", article 54 of title 22, C.R.S. This subsection (7) applies to students who are less than twenty-two years of age.

Editor's note: This section is effective March 1, 2014.

25.5-10-207. Services and supports - waiting list reduction - cash fund. (1) There is hereby created in the state treasury the intellectual and developmental disabilities services cash fund, consisting of moneys appropriated thereto by the general assembly and any moneys transferred to the intellectual and developmental disabilities services cash fund pursuant to subsection (1.5) of this section. Any interest derived from the deposit and investment of moneys in the intellectual and developmental disabilities services cash fund shall be credited to the fund. Any moneys remaining in the fund at the end of a fiscal year shall remain in the fund and shall not revert to the general fund or any other fund.

(1.5) The state treasurer shall transfer to the developmental disabilities services cash fund any available moneys that are appropriated by the general assembly for a fiscal year for adult comprehensive services, adult supported living services, children's extensive support services, and family support services for persons with intellectual and developmental disabilities provided pursuant to this article or part 4 of article 6 of this title that are unexpended and unencumbered at the end of a fiscal year.

(2) During each regular session of the general assembly, the joint budget committee and the health and human services committees of the senate and the house of representatives, or any successor committees, shall hold a joint hearing and take public testimony on the status of the waiting lists for adult comprehensive services, adult supported living services, children's extensive support services, and family support services for persons with intellectual and developmental disabilities and the availability of general fund moneys to reduce the number of persons on the waiting lists and the amount of time eligible persons wait for such services. The goal of the hearing shall be to propose an appropriation from the general fund to the intellectual and developmental disabilities services cash fund.

(3) The general assembly may annually appropriate moneys in the intellectual and developmental disabilities services cash fund to the state department for program costs for adult comprehensive services, adult supported living services, children's extensive support services, and family support services for persons with intellectual and developmental disabilities provided pursuant to this article or part 4 of article 6 of this title.

(4) Any moneys appropriated from the intellectual and developmental disabilities services cash fund pursuant to subsection (3) of this section that are unexpended at the end of a fiscal year shall revert to the fund.

(5) It is the intent of the general assembly that the moneys in the intellectual and developmental disabilities services cash fund be used to reduce the number of persons on the waiting lists for such services and the amount of time eligible persons wait for such services.

Editor's note: This section is effective March 1, 2014.

25.5-10-208. Service agencies - moneys - rules. (1) A service agency, including a community-centered board when acting as a service agency, shall comply with the requirements set forth in this article and the rules promulgated thereunder.

(2) The state board shall promulgate rules to implement the purchase of services and supports from a community-centered board, service agency, or family caregiver. The rules shall include, but need not be limited to:

(a) Terms and conditions necessary to promote the effective delivery of services and supports, including those services and supports delivered by a family caregiver;

(b) Procedures for obtaining an annual audit of designated community-centered boards and service agencies not affiliated with a designated community-centered board to provide financial information deemed necessary by the state department to establish costs of services and supports and to ensure proper management of moneys received pursuant to section 25.5-10-206;

(c) Delineation of a system to resolve contractual disputes between the state department and designated community-centered boards or service agencies and between designated community-centered boards and service agencies, including the contesting of any rates that the designated community-centered boards charge to service agencies based upon a percentage of the rates that service agencies charge for services and supports;

(d) Specification of which services and supports are to be reimbursed by the state department and secondarily by the community-centered board, the source of reimbursement, actual service or support costs, incentives, and program service objectives that affect reimbursement;

(e) The methods of coordinating the purchase of services and supports, including but not limited to service and support coordination, with other federal, state, and local programs that provide funding for authorized services and supports; and

(f) Criteria for and limitations on any rates that designated community-centered boards charge to service agencies based upon a percentage of the rates that service agencies charge for services and supports.

(3) Any incorporated service agency that is registered in Colorado as a foreign corporation shall organize a local advisory board consisting of persons who reside within the designated service area. Such advisory board shall be representative of the community at large and persons receiving services and their families.

(4) Upon a determination by the executive director that services or supports have not been provided in accordance with the program or financial administration standards specified in this article and the rules promulgated thereunder, the executive director may reduce, suspend, or withhold payment to a designated community-centered board, service agency under contract with a designated community-centered board, or service agency from which the state department purchased services or supports directly. When the executive director decides to reduce, suspend, or withhold payment, the executive director shall specify the reasons therefor and the actions that are necessary to bring the designated community-centered board or service agency into compliance.

(5) Nothing in this article or in any rules promulgated pursuant thereto and no actions taken by the executive director pursuant to this article shall be construed to affect the obtaining of funds from local authorities, including those funds obtained from a mill levy assessed by a county or municipality for the purpose of purchasing services or supports for persons with intellectual and developmental disabilities, or to require that such funds from local authorities be used to supplant state or federal funds available for purchasing services and supports for persons with developmental disabilities.

Editor's note: This section is effective March 1, 2014.

25.5-10-209. Community-centered boards - designation - purchase of services and supports by community-centered boards. (1) In order to be designated as the community-centered board in a particular designated service area, a private for-profit or not-for-profit corporation shall annually apply for such designation to the state department in the form and manner specified by the executive director. Designation shall be based on the following factors:

(a) Utilization of existing service agencies or existing social networks or natural sources of support in the designated service area;

(b) Encouragement of competition among service agencies within the designated service area to provide newly identified services or supports, the variety of service agencies available to the person receiving services within the designated service area, and the demonstrated effort to purchase new or expanded services or supports from service agencies other than those affiliated with the community-centered board;

(c) Utilization of state-funded services and supports administered at the local level, including but not limited to public education, social services, public health, and

rehabilitation programs;

(d) Quality of services and supports provided directly or by contract for persons with intellectual and developmental disabilities;

(e) The establishment of new services and supports for the prevention of institutionalization, the support of deinstitutionalization, and a commitment to innovative, effective, and inclusive services and supports for persons with intellectual and developmental disabilities; and

(f) The willingness of the applicant to pursue authorized services and supports from all eligible persons within the designated service area.

(2) Once a community-centered board has been designated pursuant to this section, it shall, subject to available appropriations:

(a) Be under the control and direction of a board of directors or trustees composed of one or more persons from each of the following categories:

(I) Interested persons representing the community at large;

(II) Family members of persons with intellectual and developmental disabilities who are receiving services or supports; and

(III) Persons with intellectual and developmental disabilities who are receiving services or supports;

(b) Adopt by-law provisions to ensure that:

(I) Members of the governing board are prohibited from voting on issues in which they have a conflict of interest;

(II) Staff members of the community-centered board and employees or board members of service agencies may not serve on the governing board;

(III) Staff members of the community-centered board and employees or board members of service agencies are prohibited from voting in elections for members of the governing board; and

(IV) Board meetings must be scheduled after adequate notice and must be open to the public; except that, by vote of a two-thirds majority of members present, the board may elect to address the following matters in executive session:

(A) The purchase, acquisition, lease, transfer, or sale of any real, personal, or other property interest;

(B) Conferences with an attorney for the purpose of receiving legal advice on specific legal questions;

(C) Matters required to be kept confidential by federal or state law or rules;

(D) Specialized details of security arrangements or investigations;

(E) Determining positions relative to matters that may be subject to negotiations;

(F) Developing strategy for negotiations and instructing negotiators; and

(G) Personnel matters;

(c) Determine the needs of eligible persons within the community-centered board designated service area and prepare and implement a long-range plan and annual updates

to that plan for the development and coordination of services and supports to address those needs. The needs determination and designated service area plans or annual update shall be submitted to the state department.

(d) Determine eligibility and develop an individualized plan for each person who receives services or supports pursuant to section 25.5-10-211; except that, for a child from birth through two years of age, eligibility determination and development of an individualized family service plan are made pursuant to the provisions of part 7 of article 10.5 of title 27, C.R.S.;

(e) Provide case management services, including service and support coordination and periodic reviews, for persons receiving services and families with children with intellectual and developmental disabilities or delays;

(f) Obtain or provide early intervention services and supports pursuant to the provisions of part 7 of article 10.5 of title 27, C.R.S.;

(g) Take steps to notify eligible persons, and their families as appropriate, regarding the availability of services and supports; and

(h) Establish a human rights committee. The human rights committee is composed, to the extent possible, of two professional persons trained in the application of behavior development techniques and three representatives of persons receiving services, their parents, legal guardians, or authorized representatives. An employee or board member of a service agency within the community-centered board's designated service area shall not serve as a member of the human rights committee.

(3) The executive director shall review each designated community-centered board program to ensure that the program complies with the requirements and standards set forth in this article and the rules promulgated thereunder.

Editor's note: This section is effective March 1, 2014.

25.5-10-210. Revocation of designation. (1) The executive director may revoke the designation of a community-centered board upon a finding that the community-centered board is in violation of the provisions of this article and the rules promulgated thereunder. Such revocation shall conform to the provisions and procedures specified in article 4 of title 24, C.R.S., and shall be made only after a hearing is provided as specified in that article.

(2) Once a designation has been revoked pursuant to subsection (1) of this section, the executive director may designate a service agency to perform the case management services of the designated community-centered board pending designation of a new community-centered board.

Editor's note: This section is effective March 1, 2014.

25.5-10-211. Eligibility determination - individualized plan - periodic review - rules. (1) (a) Any person may request an evaluation to determine whether he or she has an intellectual and developmental disability and is eligible to receive services and supports pursuant to this article. The person must apply for eligibility determination to the designated community-centered board in the designated service area where the person resides.

(b) Pursuant to the contract with the state department, designated community-centered boards shall determine whether a person is eligible to receive services and supports pursuant to this article and, if so, shall develop an individualized plan for him or her as part of his or her enrollment into a program. The state board shall promulgate rules, pursuant to article 4 of title 24, C.R.S., setting forth the procedure and criteria for determination of eligibility and individualized plan development. The procedure and criteria shall be uniform in nature and applied throughout the state in a consistent manner.

(2) Following intake and assessment, the designated community-centered board shall develop an individualized plan as provided by rules promulgated by the state board. The designated community-centered board shall develop an individualized family service plan for a child with disabilities from birth through two years of age pursuant to section 27-10.5-703, C.R.S.

(3) Subject to available appropriations pursuant to section 25.5-10-206 and to the capacity of an individual service agency, the person with an intellectual and developmental disability must be provided options for services and supports within the designated service area that can appropriately meet the person's identified needs, as identified pursuant to subsection (2) of this section, and may select the service agency from which to receive services or supports.

(4) (a) Each person receiving services must receive periodic and adequate reviews to ascertain whether the services and supports specified in his or her individualized plan have been provided, determine the appropriateness of current services and supports, identify whether the outcomes specified in the person's individualized plan have been achieved, and modify and revise current services or supports to meet the identified needs and preferences of the person receiving services. The designated community-centered board shall develop modifications or revisions to the individualized family service plan for a child with disabilities from birth through two years of age pursuant to section 27-10.5-703, C.R.S.

(b) In order to accurately review the services and supports being provided, the community-centered board or regional center may make cognitive, physical, medical, behavioral, social, vocational, educational, or other necessary types of evaluations of a person receiving services. An intellectual and developmental disabilities professional

shall supervise the reviews. The person receiving services, the parents or guardian of a minor, or the guardian of the person receiving services, and the authorized representative of the person receiving services may attend and shall receive adequate advance notice of the reviews. Parental or legal guardian consent must be obtained prior to administering evaluations for program review to minors. The results of a review must be given to the person receiving services and to the person's parent, or guardian, as appropriate, and must be made a part of the person's record.

(c) A person's individualized plan must be reviewed at least annually; except that an individualized family service plan for a child with disabilities from birth through two years of age must be reviewed as required pursuant to part 7 of article 10.5 of title 27, C.R.S.

(5) An individualized plan is not required for a person with intellectual and developmental disabilities who is eligible for supports and services and who is on a waiting list for enrollment into a program funded pursuant to this article. Each community-centered board shall provide information and referral services to each person on the waiting list for enrollment in a program, at the time of his or her eligibility and annually thereafter, regarding services and supports that are relevant to persons and are commonly used by persons with intellectual and developmental disabilities as provided by rules promulgated by the state board. The criteria for information and referral shall be uniform in nature and applied throughout the state in a consistent manner.

Editor's note: This section is effective March 1, 2014.

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 moneys pursuant to section 25.5-10-206 shall adopt a procedure for the resolution of disputes arising between the service agency and any recipient of, or applicant for, services or supports authorized under section 25.5-10-206. Procedures for the resolution of disputes regarding early intervention services must comply with IDEA and with part 7 of article 10.5 of title 27, C.R.S. The procedures must be consistent with rules promulgated by the state board pursuant to article 4 of title 24, C.R.S., and must apply to the following disputes:

- (a) A contested decision that the applicant is not eligible for services or supports;
- (b) A contested decision to provide, modify, reduce, or deny services or supports set forth in the individualized plan or individualized family service plan of the person receiving services;
- (c) A contested decision to terminate services or supports;
- (d) A contested decision that the person receiving services is no longer eligible for

services or supports.

(2) The state board shall promulgate rules pursuant to article 4 of title 24, C.R.S., setting forth procedures for the resolution of disputes specified in subsection (1) of this section that must:

(a) Require that all applicants for services and supports and the parents or guardian of a minor, the guardian, or an authorized representative be informed orally and in writing, in their native language, of the dispute resolution procedures at the time of application, at the time the individualized plan is developed, and any time changes in the plan are contemplated;

(b) Require that a service agency keep a written record of all proceedings specified pursuant to this section;

(c) Require that no person receiving services be terminated from such services or supports during the resolution process;

(d) Require that utilizing the dispute resolution procedure must not prejudice the future provision of appropriate services or supports to persons; and

(e) Require that the intended action not occur until after reasonable notice has been provided to the person, the parents or guardian of a minor, the guardian, or an authorized representative, along with an opportunity to utilize the resolution process, except in emergency situations, as determined by the state department.

(3) The resolution process need not 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 procedures, time frames, notice, an opportunity to be heard and to present evidence, and the opportunity for impartial review of the decision in dispute by the executive director or designee, if the resolution process has failed.

Editor's note: This section is effective March 1, 2014.

25.5-10-213. Discharge. (1) A person receiving services must be discharged from services or supports upon a determination, made pursuant to the individualized planning process, that the services or supports are no longer appropriate. At least ten days prior to effectuation of the discharge, notification of discharge must be given to the person receiving services, the parents or guardian of such a person who is a minor, and the person's legal guardian and authorized representative when applicable.

(2) When a person receiving services notifies a service agency that the person no longer wishes to receive a service or support, the person must be discharged from the service or support unless the person is subject to a petition to impose a legal disability or to remove a legal right, filed pursuant to section 25.5-10-216, or for whom a legal guardian has been appointed, affecting the person's ability to voluntarily terminate

services or supports. The parents of the person receiving services who is a minor and such person's guardian must be notified of the person's wish to terminate services or supports, but no minor will be discharged without the consent of the parent or legal guardian.

Editor's note: This section is effective March 1, 2014.

25.5-10-214. Community residential home - licenses - rules. (1) The department of public health and environment and the state department shall implement a system of joint licensure and certification of community residential homes. Independent residential support services provided by the state department do not require licensure by the department of public health and environment.

(2) (a) The department of public health and environment and the state department shall develop standards for the licensure and certification of community residential homes. The standards shall include health, life, and fire safety, as well as standards to ensure the effective delivery of services and supports to residents; except that any community residential home must comply with local codes.

(b) (I) The state department or the state board of health, as appropriate, shall adopt the standards by rule and shall specify the responsibilities of each department in the program. Surveys undertaken to ensure compliance with these standards shall, as appropriate, be undertaken as joint surveys by the departments.

(II) If a service agency operates a community residential home and provides personal care services, as defined in section 25-27.5-102, C.R.S., the department of public health and environment or the state department, as appropriate, is responsible for surveying those services provided by the service agency, which survey shall be conducted simultaneously with the survey of the community residential home.

(3) Any community residential home applying for a license or certification on or after January 1, 1986, shall accommodate at least four but no more than eight persons with intellectual and developmental disabilities. All licenses and certificates issued by the department of public health and environment or the state department shall bear the date of issuance and shall be valid for not more than a twenty-four-month period.

(4) The issuance, suspension, revocation, modification, renewal, or denial of a license or certification shall be governed by the provisions of section 24-4-104, C.R.S. The failure of a community residential home to comply with the provisions of this article and the rules promulgated thereunder, or any local fire, safety, and health codes shall be sufficient grounds for the department of public health and environment or the state department to deny, suspend, revoke, or modify the community residential home's license or certification.

(5) The state department and the state board of health shall promulgate such rules

as are necessary to implement this section, pursuant to the provisions specified in article 4 of title 24, C.R.S. The rules shall include, but shall not be limited to, the following:

(a) Requirements concerning the distance between the location of community residential homes and factors to be considered in waiving such requirements for existing community residential homes;

(b) Procedures to secure the health and safety of persons receiving services or supports residing in a community residential home in the event the community residential home closes or its license is denied, suspended, or revoked pursuant to this section; and

(c) Prohibiting the cultivation, use, or consumption of retail marijuana on the premises of a community residential home.

Editor's note: This section is effective March 1, 2014.

25.5-10-215. Compliance with local government zoning regulations - notice to local governments - provisional licensure. (1) The state department shall require any community residential home seeking licensure pursuant to section 25.5-10-214 to comply with any applicable zoning regulations of the municipality, city and county, or county where the home is situated. Failure to comply with applicable zoning regulations shall constitute grounds for the denial of a license to a home; except that nothing in this section shall be construed to supersede the provisions of sections 30-28-115 (2), 31-23-301 (4), and 31-23-303 (2), C.R.S.

(2) The state department shall ensure that timely written notice is provided to the municipality, city and county, or county where a community residential home is situated, including the address of the home and the population and number of persons to be served by the home, when any of the following occurs:

(a) An application for a license to operate a community residential home pursuant to section 25.5-10-214 is made;

(b) A license is granted to a community residential home pursuant to section 25.5-10-214;

(c) A change in the license of a community residential home occurs; or

(d) The license of a community residential home is revoked or otherwise terminated for any reason.

(3) In the event of a zoning or other delay or dispute between a community residential home and the municipality, city and county, or county where the home is situated, the state department may grant a provisional license to the home for up to one hundred twenty days pending resolution of the delay or dispute.

Editor's note: This section is effective March 1, 2014.

25.5-10-216. Imposition of legal disability - removal of legal right. (1) Any interested person may petition the court to impose a legal disability on or to remove a legal right from a person with an intellectual and developmental disability as defined in section 25.5-10-202. The petition must set forth the disability to be imposed or the legal right to be removed and the reasons therefor. The petition may affect the right to contract, the right to determine place of abode or provisions of services and supports, the right to operate a motor vehicle, and other similar rights.

(2) (a) Prior to granting the petition, the court must find:

(I) That the person subject to the petition has been determined to be a person with an intellectual and developmental disability pursuant to the provisions of this article; and

(II) That the requested disability or removal is both necessary and desirable to implement the individualized plan developed for the person receiving services or supports under the supervision of an intellectual and developmental disabilities professional and the interdisciplinary team. Such professional must have an understanding of the rights of persons receiving services as set forth in sections 25.5-10-218 to 25.5-10-229. Such plan must be submitted to the court and must be signed by the intellectual and developmental disabilities professional.

(b) When a petition filed pursuant to subsection (1) of this section seeks to impose a disability or to remove a legal right, related to the selection of place of abode by the person with an intellectual and developmental disability, the court must also find:

(I) That, based on the recent overt actions or omissions of the person subject to the petition, and because of the presence of an intellectual and developmental disability, without the relief requested in the petition such person poses a probable threat of serious physical harm to such person or others or is unable to care for such person's own needs to the extent that such person's own life or safety is seriously threatened; and

(II) That the place of abode requested in the petition is the least restrictive residential setting that is appropriate for the individual needs of the person with an intellectual and developmental disability.

(3) Within six months after a legal disability has been imposed or a legal right has been removed, the court shall hold a hearing to review its order and either reaffirm the findings made pursuant to subsection (2) of this section and continue the legal disability or removal or remove the legal disability or restore the legal rights to the person subject to the petition. The court may remove a legal disability from or restore a legal right to a person without a hearing upon the filing of a motion requesting such relief containing affidavits in support of the motion signed by all of the parties.

(4) Any interested person may move that the court remove a legal disability or restore a legal right. If such motion is contested, it must be served on the person whose rights are affected and upon the party who filed the original petition if the person is not

the moving party.

(5) The following procedures must apply to any proceedings instituted pursuant to this section:

(a) When a petition is filed pursuant to subsection (1) of this section, the person subject to the petition shall be advised by the court of such person's right to retain and consult with an attorney at any time, and that if such person cannot afford to pay an attorney, one will be appointed by the court without cost. Attorney fees for court-appointed counsel shall be paid by the court.

(b) Upon the request of an indigent respondent or such respondent's attorney, the court shall appoint one or more intellectual and developmental disabilities professionals of the respondent's choice to assist the respondent in the preparation of the respondent's case. The court shall pay the fees for such intellectual and developmental disabilities professionals.

(c) The court may issue a temporary order imposing a legal disability or removing a legal right, pending a hearing, for a period not to exceed ten days, based upon the standards required for issuance of a temporary restraining order. No individualized plan shall be required by the court to support the issuance of such order.

(d) The burden of proof is at all times upon the party seeking imposition of a disability or removal of a legal right or opposing removal of a disability or restoration of a legal right, and the standard of proof is by clear and convincing evidence.

(e) Except as otherwise provided in this subsection (5), all proceedings must be held in conformance with the Colorado rules of civil procedure, but no costs must be assessed against the respondent.

(6) In order to provide representation to eligible persons as provided in this section, the judicial department may pay moneys, out of appropriations made therefor by the general assembly, directly to appointed counsel or intellectual and developmental disabilities professionals on a case-by-case basis or, on behalf of the state, to contract with individual attorneys, legal partnerships, legal professional corporations, public interest law firms, or nonprofit legal services corporations to provide legal representation for an agreed-upon lump sum.

(7) A person shall not be admitted to a regional center, as defined in section 27-10.5-102, C.R.S., without a court order issued pursuant to this section except in an emergency or for the purpose of temporary respite care.

Editor's note: This section is effective March 1, 2014.

25.5-10-217. Conduct of court proceedings. All court proceedings arising under section 25.5-10-216 shall be conducted by the district attorney of the county where the

proceeding is held or by a qualified attorney acting for the district attorney appointed by the district court for that purpose; except that, in any county or in any city and county having a population exceeding one hundred thousand persons, the proceedings shall be conducted by the county attorney or by a qualified attorney acting for the county attorney appointed by the district court. In any case in which there has been a change of venue to a county other than the county of residence of the respondent or the county in which the proceeding was commenced, the county from which the proceeding was transferred shall either reimburse the county in which the proceeding was held for the reasonable costs incurred in conducting the proceeding or conduct the proceeding itself using its own personnel and resources, including its own district or county attorney, as the case may be.

Editor's note: This section is effective March 1, 2014.

25.5-10-218. Persons' rights. (1) Unless a person's rights are modified by court order, a person with an intellectual and developmental disability has the same legal rights and responsibilities guaranteed to all other persons under the federal and state constitutions and federal and state laws. No otherwise qualified person, by reason of having an intellectual and developmental disability, may be excluded from participation in, denied the benefits of, or subjected to discrimination under any program or activity which receives public funds.

(2) The receipt of services and supports pursuant to this article does not deprive any person of any other rights, benefits, or privileges or cause the person to be declared legally incompetent.

(3) The rights of any person receiving services which are specified in this article may be suspended to protect the person receiving services from endangering such person, others, or property. Such rights may be suspended only by the intellectual and developmental disabilities professional with subsequent review by the interdisciplinary team and by the human rights committee in order to provide specific services or supports to the person receiving services, which will promote the least restriction on the person's rights. Such person's legal rights may be removed by a court pursuant to section 25.5-10-216.

(4) None of the rights established pursuant to this article shall be construed to interfere with the rights and privileges of parents regarding their minor child.

Editor's note: This section is effective March 1, 2014.

25.5-10-219. Right to individualized plan or individualized family service plan. (1) Each person receiving services shall have an individualized plan, an individualized family service plan, or a similar plan specified by the state department that qualifies as an individualized plan that is developed by the person's interdisciplinary team. The individualized family service plan for a child with disabilities from birth through two years of age shall be developed in compliance with part 7 of article 10.5 of title 27, C.R.S.

(2) Pursuant to section 25.5-10-211, the individualized plan for each person who receives services or supports shall be reviewed at least annually and modified as necessary or appropriate; except that an individualized family service plan for a child with disabilities from birth through two years of age shall be reviewed as required pursuant to part 7 of article 10.5 of title 27, C.R.S. A review shall consist of, but is not limited to, the determination by the interdisciplinary team as to whether the needs and preferences of the person receiving services or supports are accurately reflected in the plan, whether the services and supports provided pursuant to the plan are appropriate to meet the person's needs and preferences, and what actions are necessary for the plan to be achieved.

Editor's note: This section is effective March 1, 2014.

25.5-10-220. Right to medical care and treatment. (1) Each person receiving services must have access to appropriate dental and medical care and treatment for any physical ailments and for the prevention of any illness or disability.

(2) No medication for which a prescription is required shall be administered without the written order of a physician. A physician shall conduct a review of all prescriptions and other orders for medications in order to determine the appropriateness of the person's medication regimen annually, or more often, if required by law.

(3) All service agencies which administer medication shall require that notation of the medication of a person receiving services be kept in the person's medical records. All medications must be administered pursuant to part 3 of article 1.5 of title 25, C.R.S.

(4) Persons receiving services must have a right to be free from unnecessary or excessive medication. The service agency's records must state the effects of psychoactive medication if administered to the person receiving services. When dosages of such are changed or other psychoactive medications are prescribed, a notation must be made in such person's record concerning the effect of the new medication or new dosages and the behavior changes, if any, which occur.

(5) Medication must not be used for the convenience of the staff, for punishment, as a substitute for a treatment program, or in quantities that interfere with the treatment program of the person receiving services.

(6) Only appropriately trained staff shall be allowed to administer medications.

(7) The executive director has the power to direct the administration or monitoring of medications to persons receiving services and supports in centers for persons with intellectual and developmental disabilities pursuant to section 25-1.5-301 (2) (h), C.R.S.

(8) No person receiving services may be subjected to any experimental research or hazardous treatment procedures without the consent of such person, if the person is over eighteen years of age and is able to give such consent, or of the person's parent, if the person is under eighteen years of age, or of the person's legal guardian. Such consent may be given only after consultation with the interdisciplinary team and an intellectual and developmental disabilities professional not affiliated with the facility or community residential home in which the person receiving services resides. However, no such person of any age may be subjected to experimental research or hazardous treatment procedures if said person implicitly or expressly objects to such procedure.

(9) No person receiving services may have any organs removed for the purpose of transplantation without the consent of such person, if the person is over eighteen years of age and is able to give such consent. If the person's ability to give consent to the medical procedure is challenged by the physician, the same procedures as those set forth in section 25.5-10-232 shall be followed. Consent for the removal of organs for transplantation may be given by the parents of a person receiving services, if the person is under eighteen years of age, or by the person's legal guardian. Such consent may be given only after consultation with the interdisciplinary team and an intellectual and developmental disabilities professional not affiliated with the facility or community residential home in which the person receiving services resides. However, no person receiving services of any age may be a donor of an organ if the person implicitly or expressly objects to such procedure.

(10) (a) As used in subsections (8) and (9) of this section, consent also requires that the person whose consent is sought has been adequately and effectively informed as to the:

- (I) Method of experimental research, hazardous treatment, or transplantation;
- (II) Nature and consequence of such procedures; and
- (III) Risks, benefits, and purposes of such procedures.

(b) The consent of any person may be revoked at any time.

(11) Subsections (8), (9), and (10) of this section do not apply when a physician renders emergency medical care or treatment to any resident.

Editor's note: This section is effective March 1, 2014.

25.5-10-221. Right to humane treatment. (1) Corporal punishment of persons with an intellectual and developmental disability is not permitted.

(2) All service agencies shall prohibit mistreatment, exploitation, neglect, or abuse in any form of any person receiving services.

(3) Service agencies shall provide every person receiving services with a humane physical environment.

(4) Each person receiving services must be attended to by qualified staff in numbers sufficient to provide appropriate services and supports.

(5) Seclusion, defined as the placement of a person receiving services alone in a closed room for the purpose of punishment, is prohibited.

(6) "Time out" procedures, defined as separation from other persons receiving services and group activities, may be employed under close and direct professional supervision, as defined by rule by the state board, and only as a technique in behavior-shaping programs. Behavior-shaping programs utilizing a "time out" procedure may be implemented only when it incorporates a positive approach designed to result in the acquisition of adaptive behaviors. Such behavior programs may only be implemented following the completion of a comprehensive functional analysis, when alternative nonrestrictive procedures have been proven to be ineffective, and only with the informed consent of the person, parents, or legal guardian. Such behavior programs may be implemented only following the review and approval process defined in rules. Behavior development programs must be developed in conjunction with the interdisciplinary team and implemented only following review by the human rights committee. Behavior development programs involving the use of the procedure in a "time out room" are prohibited.

(7) Behavior development programs involving the use of aversive or noxious stimuli are prohibited.

(8) Physical restraint, defined as the use of manual methods intended to restrict the movement or normal functioning of a portion of a person's body through direct contact by staff, may be employed only when necessary to protect the person receiving services from injury to self or others. Physical restraint may not be employed as punishment, for the convenience of staff, or as a substitute for a program of services and supports. Physical guidance or prompting techniques of short duration such as those employed in training techniques are not considered physical restraint. Physical restraint may be applied only if alternative techniques have failed and only if such restraint imposed the least possible restriction consistent with its purpose. If physical restraint is used in an emergency or on a continuing basis its use shall be reviewed by the interdisciplinary team and the human rights committee in accordance with the rules of the state board.

(9) The use of a mechanical restraint, defined as the use of mechanical devices intended to restrict the movement or normal functioning of a portion of a person's body, is subject to special review and oversight, as defined in rules. Use of mechanical restraints may be applied only in an emergency if alternative techniques have failed and in conjunction with a behavior development program. Mechanical restraints must be

designed and used so as not to cause physical injury to the person receiving services and so as to cause the least possible discomfort. The use of mechanical restraints shall be reviewed by the human rights committee. The use of posey vests, straight jackets, ankle and wrist restraints, and other devices defined in rules is prohibited.

(10) A record must be maintained of all physical injuries to any person receiving services, all incidents of mistreatment, exploitation, neglect, or abuse, and all uses of physical or mechanical restraint. All records are subject to review by the human rights committee.

(11) Behavior development programs must be supervised by an intellectual and developmental disabilities professional having specific knowledge and skills to develop and implement positive behavioral intervention strategies.

Editor's note: This section is effective March 1, 2014.

25.5-10-222. Right to religious belief, practice, and worship. No person receiving services is required to perform any act or be subject to any procedure whatsoever which is contrary to the person's religious belief, and each such person has the right to practice such religious belief and be accorded the opportunity for religious worship. Provisions for religious worship must be made available to all persons receiving services on a nondiscriminatory basis. No such person shall be coerced into engaging in or refraining from any religious activity, practice, or belief.

Editor's note: This section is effective March 1, 2014.

25.5-10-223. Rights to communications and visits. (1) Each person receiving services has the right to communicate freely and privately with others of the person's own choosing.

(2) Each person receiving services has the right to receive and send sealed, unopened correspondence. No such person's incoming or outgoing correspondence shall be opened, delayed, held, or censored by any person.

(3) Each person receiving services shall have the right to receive and send packages. No such person's outgoing packages shall be opened, delayed, held, or censored by any person.

(4) Each person receiving services must have reasonable access to telephones, both to make and to receive calls in privacy, and must be afforded reasonable and frequent opportunities to meet with visitors.

(5) All service agencies shall ensure that persons receiving services have suitable opportunities for interaction with persons of their choice. Nothing in this section will limit the protections provided under article 3.1 of title 26, C.R.S.

Editor's note: This section is effective March 1, 2014.

25.5-10-224. Right to fair employment practices. (1) No person receiving services shall be required to perform labor; except that persons receiving services may voluntarily engage in such labor if the labor is compensated in accordance with applicable minimum wage laws.

(2) No person receiving services shall be involved in the physical care, care and treatment, training, or supervision of other persons receiving services unless such person has volunteered, has been specifically trained in the necessary skills, and has the judgment required for such activities, is adequately supervised, and is reimbursed in accordance with the applicable minimum wage laws.

(3) Each person receiving services may perform vocational training tasks, subject to a presumption that an assignment longer than three months to any task is not a training task, if the specific task or any change in task assignment is an integral part of such person's individualized plan. If such person performs vocational training tasks for which the service agency is receiving compensation from any outside source, the person shall be compensated in accordance with the applicable minimum wage laws.

(4) Each person receiving services may voluntarily engage in labor for which the service agency would otherwise have to pay an employee if the specific labor or any change in labor is an integral part of such person's individualized plan and the person is compensated in accordance with the applicable minimum wage laws.

(5) Each person receiving services may be required to perform tasks of a personal housekeeping nature or tasks oriented to improving community living skills in accordance with the person's individualized plan.

(6) Payment to persons receiving services pursuant to this section shall not be collected by the service agency to offset the costs of providing services and supports to such person.

Editor's note: This section is effective March 1, 2014.

25.5-10-225. Right to vote. Each person receiving services who is eligible to vote according to law has the right to vote in all primary and general elections. As necessary,

all service agencies shall assist such persons to register to vote, to obtain mail ballots, to comply with other requirements that are prerequisite to voting, and to vote.

Editor's note: This section is effective March 1, 2014.

25.5-10-226. Records and confidentiality of information pertaining to eligible persons or their families. (1) A record for each person receiving services shall be diligently maintained by the community-centered board. The record must include, but not be limited to, information pertaining to the determination of eligibility for services and the individualized plan. The record is not a public record.

(2) Except as otherwise provided by law, all information obtained and any records prepared in the course of determining eligibility or providing services and supports pursuant to this article are confidential and subject to the evidentiary privileges established by law. The disclosure of this information and these records in any manner shall be permitted only:

(a) To the applicant or person receiving services, to the parents of a minor, to such person's legal guardian, and to any person authorized by the above named person;

(b) In communications between qualified professional personnel, including the board of directors of community-centered boards and service agencies providing services to persons with intellectual and developmental disabilities, to the extent necessary for the acquisition, provision, oversight, or referral of services and supports;

(c) To the extent necessary to make claims for aid, insurance, or medical assistance to which a person receiving services may be entitled, or to access services and supports pursuant to the individualized plan;

(d) For the purposes of evaluation, gathering statistics, or research when no identifying information concerning an individual person or family is disclosed. Identifying information is information which could reasonably be expected to identify a specific person and includes, but is not limited to, name, address, telephone number, social security number, medicaid number, household number, and photograph.

(e) To the court when necessary to implement the provisions of this article;

(f) To persons authorized by an order of court issued after a hearing, notice of which was given to the person, parents or legal guardian, where appropriate, and the custodian of the information;

(g) To the agency designated pursuant to 42 U.S.C. sec. 6012 as the protection and advocacy system for Colorado when:

(I) A complaint has been received by the protection and advocacy system from or on behalf of a person with an intellectual and developmental disability; and

(II) Such person does not have a legal guardian or the state or the designee of the

state is the legal guardian of such person;

(h) To the state department or its designees as deemed necessary by the executive director to fulfill the duties prescribed by this article.

(3) Nothing in this section shall be construed to limit access by a person receiving services to such person's records.

(4) Nothing in this section shall be construed to interfere with the protections afforded to a person under the federal "Health Insurance Portability and Accountability Act of 1996", 42 U.S.C. sec. 1320d, and the federal "Family Education Rights and Privacy Act of 1974", 20 U.S.C. sec. 1232g.

Editor's note: This section is effective March 1, 2014.

25.5-10-227. Right to personal property. (1) Each person receiving services has the right to the possession and use of such person's own clothing and personal effects. If the service agency holds any of such person's personal effects for any reason, such retention shall be promptly recorded in such person's record and the reason for retention shall also be recorded.

(2) Upon the request of a person receiving services, a service agency may hold money or funds belonging to the person receiving services, received by such person, or received by the service agency for such person. All such money or funds shall be held by the service agency as trustee for the person receiving services. Upon request, an accounting shall be rendered by the service agency.

(3) Upon request, a person receiving services is entitled to receive reasonable amounts of such person's money or funds held in trust.

Editor's note: This section is effective March 1, 2014.

25.5-10-228. Right to influence policy. The persons receiving services of a service agency are entitled to establish a committee to hear the views and represent the interests of all such persons served by the agency and to attempt to influence the policies of the agency to the extent that they influence provision of services and supports.

Editor's note: This section is effective March 1, 2014.

25.5-10-229. Right to notification. Each person receiving services has the right to read or have explained, in each person's or family's native language, any rules adopted by the service agency and pertaining to such person's activities.

Editor's note: This section is effective March 1, 2014.

25.5-10-230. Discrimination. No person who has received services or supports under any provision of this article shall be discriminated against because of such status. For purposes of this section, "discrimination" means the giving of any unfavorable weight to the fact that a person has received such services or supports.

Editor's note: This section is effective March 1, 2014.

25.5-10-231. Sterilization rights. (1) It is the intent of the general assembly that the procedures set forth in the following subsections be utilized when sterilization is being considered for the primary purpose of rendering the person incapable of reproduction.

(2) Any person with an intellectual and developmental disability over eighteen years of age who has given informed consent has the right to be sterilized, subject to the following:

(a) Prior to the procedure, competency to give informed consent and assurance that such consent is voluntarily and freely given shall be evaluated by the following:

(I) A psychiatrist, psychologist, or physician who does not provide services or supports to the person and who has consulted with and interviewed the person with an intellectual and developmental disability; and

(II) An intellectual and developmental disabilities professional who does not provide services or supports in which said person participates, and who has consulted with and interviewed the person with an intellectual and developmental disability.

(b) The professionals who conducted the evaluation pursuant to paragraph (a) of this subsection (2) shall consult with the physician who is to perform the operation concerning each professional's opinion in regard to the informed consent of the person requesting the sterilization.

(3) Any person with an intellectual and developmental disability whose capacity to give an informed consent is challenged by the intellectual and developmental disabilities professional or the physician may file a petition with the court to declare competency to give consent pursuant to the procedures set forth in section 25.5-10-232.

(4) No person with an intellectual and developmental disability who is over eighteen years of age and has the capacity to participate in the decision-making process regarding sterilization shall be sterilized in the absence of the person's informed consent. No minor may be sterilized without a court order pursuant to section 25.5-10-233.

(5) Sterilization conducted pursuant to this section shall be legal. Consent given by any person pursuant to subsection (2) of this section is not revocable after sterilization, and no person shall be liable for acting pursuant to such consent.

Editor's note: This section is effective March 1, 2014.

25.5-10-232. Competency to give consent to sterilization. (1) If the competency of the person with an intellectual and developmental disability to give consent to sterilization is disputed by the intellectual and developmental disabilities professional, the psychiatrist or psychologist, or physician, said person may file a petition for declaration of competency to give consent to sterilization with the court. Upon the filing of a petition which shows that said person is over eighteen years of age and desires to give consent to sterilization, the court shall immediately set a hearing to determine the person's competency to give such consent. For the purpose of determining competency, the court shall appoint two or more independent professional persons with expertise in the field of intellectual and developmental disabilities who do not provide services and supports to said person to examine said person and to present their findings as to said person's competency to give consent to sterilization at the competency hearing.

(2) If the court determines that the person has given consent to sterilization and is competent to give such consent, the court may order that the sterilization be performed unless the person withdraws consent to sterilization prior to the sterilization being performed. If the court determines that the person is incompetent to give consent to sterilization, the court shall order that no sterilization be performed without further court proceedings pursuant to section 25.5-10-233.

(3) Determination of competency in these proceedings is specific to the ability to give consent to sterilization and does not determine legal competency for any other purpose.

Editor's note: This section is effective March 1, 2014.

25.5-10-233. Court-ordered sterilization. (1) A person with an intellectual and developmental disability who has been determined to be incompetent to give consent, the

person's legal guardian, or the parents of a minor with an intellectual and developmental disability, may petition the court to hold a hearing to determine whether said person should be ordered to be sterilized. The petition shall set forth the following:

- (a) The name, age, and residence of the person to be sterilized;
- (b) The name, address, and relation to said person of the petitioner;
- (c) The names and addresses of any parents, spouse, legal guardian, or custodian of said person;
- (d) The mental condition of the person to be sterilized;
- (e) A statement that the sterilization is medically necessary to preserve the life or physical or mental health of the person, including a short and plain description of the reasons behind the determination of medical necessity;
- (f) A statement that other less intrusive measures were considered and the reasons behind the determination that less intrusive means would not protect the interests of the person.

(2) Upon petition to the court, the court shall appoint an attorney who will represent the interests of the person with an intellectual and developmental disability and one or more experts in the intellectual and developmental disability field to examine the person and to give testimony at the hearing regarding the person's mental and physical status and other relevant matters.

(3) The hearing on the petition must be held promptly. The person with an intellectual and developmental disability must be represented by an attorney and must have the opportunity to present testimony and to cross-examine witnesses.

(4) Copies of the petition and notices of the time and place of the hearing shall be mailed, not less than ten days prior to the hearing, to the person with an intellectual and developmental disability, that person's attorney, a parent or next of kin, and legal guardian or custodian.

(5) Reasonable fees and costs incurred pursuant to this section shall be paid by the court for a person who is indigent.

(6) Prior to ordering sterilization, the court must find:

(a) That the person lacks the capacity to effectively participate in the decision-making process regarding sterilization or is a minor with an intellectual and developmental disability;

(b) That the court has heard from the person regarding that person's desires, if possible, and the court has considered the desires of the person;

(c) That the person lacks the capacity to make a decision regarding sterilization and that the person's capacity to make such a decision is unlikely to improve in the future;

(d) That the person is capable of reproduction and is likely to engage in activities at the present or in the near future which could result in pregnancy;

(e) By clear and convincing evidence, that the sterilization is medically necessary to preserve the life or physical or mental health of the person, including a short and plain

description of the reasons behind the determination of medical necessity;

(f) That other less intrusive measures were considered and the reasons behind the determination that less intrusive means would not protect the interests of the person.

Editor's note: This section is effective March 1, 2014.

25.5-10-234. Confidentiality of sterilization proceedings. All records, hearings, and proceedings pursuant to sections 25.5-10-231 to 25.5-10-233 are strictly confidential unless requested to be open to the public by the person with an intellectual and developmental disability or the person's legal guardian.

Editor's note: This section is effective March 1, 2014.

25.5-10-235. Limitations on sterilization. (1) Consent to sterilization shall be made neither a condition for release from any institution nor a condition for the exercise of any right, privilege, or freedom.

(2) Nothing in this article requires any hospital or any person to participate in any sterilization, nor shall any hospital or any person be civilly or criminally liable for refusing to participate in any sterilization.

Editor's note: This section is effective March 1, 2014.

25.5-10-236. Civil action and attorney fees. A violation of any provision of this article gives rise to a civil cause of action by the person adversely affected by such violation, and any judgment may include plaintiff's reasonable attorney fees.

Editor's note: This section is effective March 1, 2014.

25.5-10-237. Terminology. (1) Whenever the terms "insane", "insanity", "mentally or mental incompetent", "mental incompetency", or "of unsound mind" are used in the laws of the state of Colorado, they shall be deemed to refer to the insane, as defined in section 16-8-101, C.R.S., or to a person with an intellectual and developmental

disability, as defined in section 25.5-10-202, as the context of the particular law requires.

(2) Whenever the term "mentally deficient person" is used in the laws of the state of Colorado, it shall be deemed to mean and be included with the term "person with an intellectual and developmental disability", as defined in section 25.5-10-202.

Editor's note: This section is effective March 1, 2014.

25.5-10-238. Federal funds. The state department is authorized to accept, on behalf of the state, any grants of federal funds made available for any purposes consistent with the provisions of this article. The executive director of the state department, with the approval of the governor, shall have power to direct the disposition of any such grants so accepted in conformity with the terms and conditions under which they are given.

Editor's note: This section is effective March 1, 2014.

25.5-10-239. Evaluations to determine whether a defendant is mentally retarded for purposes of class 1 felony trials. Upon request of the court, the executive director, or his or her designee, shall recommend specific professionals who are qualified to perform an evaluation to determine whether a defendant is mentally retarded, as defined in section 18-1.3-1101, C.R.S. Any professional who is recommended shall be licensed as a psychologist in the state of Colorado and shall have experience in and shall have demonstrated competence in determination and evaluation of persons with mental retardation. The executive director shall convene a panel of not fewer than three persons with expertise in mental retardation who shall assess the qualifications of licensed psychologists and make recommendations to the executive director.

Editor's note: This section is effective March 1, 2014.

25.5-10-240. Retaliation prohibited. No person shall be discriminated against because he or she has made a complaint, testified, assisted, or participated in any manner in an investigation, proceeding, or hearing pursuant to this article, including the dispute resolution procedures in section 25.5-10-212 and section 27-10.5-107, C.R.S. A service agency, including the state department and any community-centered board, shall not coerce, intimidate, threaten, or interfere with any person in the exercise or enjoyment of

any right pursuant to this article, or on account of his or her having exercised or enjoyed any right pursuant to this article, or on account of his or her having aided or encouraged any other person in the exercise or enjoyment of any right pursuant to this article.

Editor's note: This section is effective March 1, 2014.

PART 3

FAMILY SUPPORT SERVICES

25.5-10-301. Legislative declaration. (1) It is the intent of the general assembly that the service delivery system for persons with intellectual and developmental disabilities emphasize community living for persons with intellectual and developmental disabilities and provide supports to persons that enable them to enjoy typical lifestyles. One way to accomplish this is to recognize that families are the greatest resource available to persons who have an intellectual and developmental disability and that families must be supported in their role as primary care givers. The general assembly finds that supporting families in their effort to provide supports for their family members at home is more efficient, cost-effective, and humane than maintaining persons with intellectual and developmental disabilities in out-of-home residential settings. In recognition of the importance of families, the general assembly states that the following principles should be used as guidelines in developing programs to support a family that has a child with disabilities:

(a) Families of persons with intellectual and developmental disabilities are best able to determine their own needs and preferences and should be empowered to make decisions concerning necessary, desirable, and appropriate services and supports;

(b) Families must receive the services and supports necessary to care for their children at home;

(c) Family support must be responsive to the needs of the entire family unit;

(d) Family support must be sensitive to the unique strengths and needs of individual families;

(e) Family support must build on existing social networks and natural sources of support;

(f) Family support is needed throughout the lifespan of the person who has a disability;

(g) Family support must encourage the inclusion of people with intellectual and developmental disabilities within the community;

(h) Family support services must be flexible enough to accommodate unique

needs of families as they evolve over time;

(i) Family support services must be consistent with the cultural preferences and orientations of individual families;

(j) Family support services should be comprehensive and coordinated across the numerous agencies likely to provide resources, supports, or services to families;

(k) Family support services should be based on the principles of sharing ordinary places, developing meaningful relationships, learning things that are useful, making choices, as well as increasing the status and enhancing the reputation of people served;

(l) Supports should be developed by the state that are necessary, desirable, and appropriate to support families;

(m) Intellectual and developmental disabilities programs and policies must enhance the development of the person with an intellectual and developmental disability and the family;

(n) State programs should provide sufficient services and supports to enable families to keep their family members with intellectual and developmental disabilities at home;

(o) A comprehensive, coordinated system of supports to families effectively uses existing resources and minimizes gaps in supports to families and persons in all areas of the state;

(p) Services and supports provided through the family support program must be closely coordinated with early intervention services and must foster collaboration and cooperation with all agencies providing services and supports to infants and preschool children; and

(q) Any rights, entitlements, services, or supports created by this part 3 are not to be considered a limitation, modification, or infringement on any existing rights, entitlements, services, or supports, otherwise expressly provided by this article.

(2) In addition, the general assembly recognizes that the state department has for several years developed and maintained a family resource service program that provides support services to families of children with intellectual and developmental disabilities who are at risk of out-of-home placement. Because of the success of this program the general assembly recommends that this valuable program be continued and expanded so that more families in this state are able to receive appropriate services, supports, and assistance needed to stabilize the family unit. In recognition of the basic goal to support families, on an individual family basis, in maintaining a person with an intellectual and developmental disability at home and in recognition of the principles stated in subsection (1) of this section, the general assembly declares that its purpose in enacting this part 3 is to create, subject to annual appropriation, a comprehensive statewide family support service program.

Editor's note: This section is effective March 1, 2014.

25.5-10-302. Purpose. The purpose of the family support services program created in this part 3 is to provide support to families in their role as primary care givers for a family member with an intellectual and developmental disability.

Editor's note: This section is effective March 1, 2014.

25.5-10-303. Administration - duties of department. (1) Subject to annual appropriation by the general assembly, the state department shall administer the family support services program and shall coordinate family support services with other existing services provided to families and individuals. Family support services must be provided in a manner that develops comprehensive, responsive, and flexible support to families in their role as the primary care givers for a family member with an intellectual and developmental disability.

(2) The state department may contract with community-centered boards and other service providers approved by the state department to provide family support services in accordance with this part 3. Programs developed shall be flexible in order to address individual family needs.

(3) In administering the family support services program, the state department shall have the following duties:

- (a) To design the program;
- (b) To pursue a family support model 200 waiver for approval by the federal health care financing administration in order to utilize medicaid funds for the provision of family support services, implemented subject to appropriation;
- (c) To develop rules to be promulgated by the state board pursuant to section 25.5-10-306, with consultation from service providers, including representatives of families of persons with intellectual and developmental disabilities;
- (d) To allocate funds;
- (e) To coordinate training and provide technical assistance to community-centered boards and service providers;
- (f) To monitor and evaluate the program;
- (g) To coordinate contracts, expenditures, and billing of the program; and
- (h) To recommend changes in the program.

(4) Subject to annual appropriation by the general assembly, out of the appropriation to the state department for community programs in the general appropriation act, the state department is authorized to use up to seven percent of such appropriation allocated for family support services to pay for administrative costs within

the state department and the community-centered boards.

Editor's note: This section is effective March 1, 2014.

25.5-10-304. Family support councils. (1) The state department shall ensure that each community-centered board establishes a family support council in each community-centered board designated service area. The family support councils shall consist of professionals, interested citizens, family members of persons with an intellectual and developmental disability, and persons with an intellectual and developmental disability with a majority of the council being made up of family members.

(2) The family support council shall:

(a) Provide direction and assistance to the community-centered board in the development of a family support plan for the designated service area;

(b) Make recommendations regarding other family supports or services not specifically listed in this part 3;

(c) Monitor the implementation of the supports or services provided pursuant to the plan; and

(d) Provide a written report to the state department of its involvement in the duties specified in this subsection (2).

Editor's note: This section is effective March 1, 2014.

25.5-10-305. Authorized family support services. (1) The family support services included in this program include, but are not limited to, family support grants, family support services coordination, information and referral, educational materials, emergency and outreach services, and other person- and family-centered assistance services such as:

(a) Medical and dental expenses not covered by medical or health insurance or other programs;

(b) Insurance expenses;

(c) Respite;

(d) Mobility aids; adaptive equipment; assistive technology, including the cost of therapies essential for a child's development, as prescribed by a physician or specialized therapist; and home adaptations;

(e) Home health services and therapies;

(f) Family counseling, training, and support groups;

- (g) Recreation and leisure needs;
- (h) Transportation;
- (i) Special diets, clothing, materials, and equipment; and
- (j) Homemaker services.

Editor's note: This section is effective March 1, 2014.

25.5-10-306. Rules. (1) The state board shall develop rules concerning:

- (a) Further definition of services and supports to be provided by the family support services program described in this part 3;
- (b) The requirements for eligibility for services and supports;
- (c) The manner of providing services and supports; and
- (d) The size, makeup, and duties of family support councils.

Editor's note: This section is effective March 1, 2014.

PART 4

COLORADO FAMILY SUPPORT LOAN FUND

25.5-10-401. Legislative declaration. The general assembly hereby finds and declares that there is a need to establish a Colorado family support loan fund to assist families in obtaining family support services for those families who choose to maintain a dependent family member with an intellectual and developmental disability in their home setting.

Editor's note: This section is effective March 1, 2014.

25.5-10-402. Colorado family support loan fund - creation - loans to families. (1) There is hereby created in the state treasury a fund to be known as the Colorado family support loan fund, referred to in this part 4 as the "fund", which shall be administered by the state department and which consists of moneys appropriated to the fund by the general assembly, interest earned on loans made out of the fund, and any moneys received pursuant to subsection (5) of this section.

(2) Moneys in the fund are continuously appropriated to the state department for the purposes of this part 4. At the end of any fiscal year, all unexpended and unencumbered moneys in the fund must remain in the fund and shall not be credited or transferred to the general fund or any other fund. All interest derived from the deposit and investment of moneys in the fund must be credited to the fund.

(3) The state department is authorized to make loans, up to a maximum amount of eight thousand dollars, out of the moneys in the fund to eligible families in order to enable them to obtain family short-term support services or equipment as defined in section 25.5-10-305. For purposes of this section, "families" has the same meaning as defined in section 25.5-10-202. The state department shall only approve loans to families who maintain a person or persons with an intellectual and developmental disability at home. The state department may establish whatever terms and conditions it deems appropriate in making such loans. The loan amount and any interest assessed to families shall be paid back to the state department. All moneys received from families to pay back loans, including the interest assessed thereon, shall be transmitted to the state treasurer, who shall credit the same to the fund. All moneys in the fund may be used by the state department to make loans as provided in this subsection (3).

(4) Subject to annual appropriation by the general assembly, the state department is hereby authorized to transfer from the appropriation for community programs in the general appropriation act up to three percent of such appropriation allocated for family short-term support services or equipment to the Colorado family support loan fund. Any moneys received as a result of this subsection (4) shall be transmitted to the state treasurer and credited to the fund.

(5) The state department is hereby authorized to receive contributions, grants, services, in-kind donations, and property from federal agencies, local governments, or private sources for use in carrying out the purposes of this part 4. Any moneys received as a result of this subsection (5) shall be transmitted to the state treasurer and credited to the fund.

Editor's note: This section is effective March 1, 2014.

25.5-10-403. Duties relating to the fund. (1) The state board has the following duties with regard to the fund:

- (a) To develop rules for the administration of the fund;
- (b) To adopt eligibility requirements for access to the fund;
- (c) To develop application and review criteria for the approval of loans from the fund; and
- (d) To establish a low-cost fixed interest rate to be applied to all loans made from

the fund.

(2) The state department has the following duties with regard to the fund:

(a) To determine effective ways to communicate the availability of the fund to eligible families;

(b) To account for the expenditures and to develop a system to ensure timely payback of any loans made pursuant to this part 4;

(c) To perform a yearly audit of the fund; and

(d) To take other measures as needed to ensure the intent and success of this part

4.

Editor's note: This section is effective March 1, 2014.