



**Report to the
Colorado General Assembly**

Health Care Task Force

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Health Care Task Force

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Executive Summary

Task Force Charge

The Health Care Task Force is charged with studying provider reimbursement issues, network adequacy, and other health care issues that affect health insurance in this state (Section 10-16-221, C.R.S.).¹ The task force must meet at least four times each year, and continues until July 1, 2010.

Task Force Activities

The Health Care Task Force met six times during the 2009 interim. Each meeting focused on a variety of health-related topics. The task force heard testimony from representatives of state agencies, advocacy groups, health care providers, health educators, and national organizations. Topics discussed included the regulation of health insurance, the state's CoverColorado insurance program, mental health and substance abuse treatment, telemedicine, and federal health care reform. In addition, as permitted by House Joint Resolution 09-1022, the Task Force to Study Home Care Placement Agencies and Home Care Workers Placed through Home Care Placement Agencies presented its recommendations to the Health Care Task Force. An opportunity for public testimony was provided at five meetings of the task force.

Gender rating and maternity coverage in health insurance. House Bill 09-1224 required the Health Care Task Force to make recommendations on whether health insurers that issue insurance policies in the individual health insurance market should be permitted to use a person's gender as a factor in determining his or her premium. The task force heard from a variety of individuals and groups regarding the use of gender as an insurance rating factor. The National Conference of State Legislatures presented information to the task force regarding which states currently prohibit insurance carriers from setting premiums based on a person's gender. A representative of the National Women's Law Center summarized data showing that in states where gender rating is permitted, women often pay more for coverage. Other presenters noted that coverage for maternity care can be expensive, and that insurance policies that include maternity coverage can be more expensive than policies without that coverage. However, the presenters also explained that insurers are not required to offer maternity coverage to individuals who purchase coverage through the individual insurance market, and that individual coverage for women is often more expensive than for men, even if maternity coverage is not included.

The committee also heard testimony from representatives of insurance carriers and brokers. These presenters noted that individual health care premiums are determined based upon an actuarial assessment of a person's expected use of health care throughout his or her life. Because, in general, women use more health care services than men, their premiums are often more expensive. Men may utilize more health care services as they age, and the disparity in premiums between men and women may become less pronounced over time. Finally, the representatives noted that the Division of Insurance is required to review health insurance premiums in order to determine if they are actuarially sound.

¹Up until its repeal on July 1, 2004, the Health Care Task Force existed in Section 26-15-107, C.R.S. The Health Care Task Force was reinstated in 2005 with the passage of Senate Bill 05-227.



As a result of its discussions, the Health Care Task Force recommends two bills related to gender rating and maternity coverage in the individual health insurance market. Bill A prohibits the use of gender as a rating factor for individual health insurance policies. Bill E requires health insurance carriers that issue individual policies to provide the same coverage for maternity care as is currently mandated for group policies regulated by the state.

CoverColorado. CoverColorado is the state's program to provide access to health insurance for individuals who have been denied coverage in the individual health insurance market. Representatives of the program explained to the task force that the current funding structure for the program is not expected to be sustainable after 2012. The board of directors for CoverColorado recently recommended that legislation be introduced to create a schedule of fees for compensating the health care providers that serve CoverColorado patients. Implementing a fee schedule will help control the costs of the program. To facilitate the recommendation of the board, the task force recommends Bill F, which allows the CoverColorado Board of Directors to establish and implement the fee schedule.

Other health insurance issues. The Health Care Task Force discussed other issues related to the regulation of health insurance. As required by House Bill 09-1102, the task force studied the issue of portability of health insurance. Because most people access health insurance through an employer, individuals may lose health insurance coverage when they leave their employment. The task force discussed methods to make health insurance more "portable" when an individual changes employers or becomes unemployed. The task force heard presentations from the National Conference of State Legislatures regarding other states' policies on insurance portability. The committee also heard from advocates regarding possible methods to improve the portability of health insurance.

As a result of its discussions related to health insurance portability and health insurance regulation generally, the task force recommends Bill D. The bill requires the Commissioner of Insurance to adopt rules establishing standard formats for certain health insurance forms provided to customers.

Mental health and substance abuse treatment. The task force heard a variety of presentations related to the need for substance abuse and mental health treatment in the state. A representative of mental health providers updated the task force on the status of mental health care in the state and described the cuts in funding for mental health services that were enacted in the past year. With regard to substance abuse, the task force received information on needle exchange programs and a proposed plan in the City of Denver designed to reduce the transmission of infectious diseases by intravenous drug users. In addition, the task force was briefed on the Screening, Brief Intervention, and Referral to Treatment Program. This program educates health care providers on how to screen and assess patients for drug and alcohol dependency and to refer the patients to treatment, if necessary.

As a result of its discussions regarding mental health and substance abuse treatment needs in the state, the Health Care Task Force recommends two bills. Bill C adds screening, brief intervention, and referral to treatment for alcohol and other substance abuse services to the list of services provided under Medicaid. Bill H requires the Department of Human Services to enter into a contract with a nonprofit entity for the provision of initial triage services through a coordinated and integrated crisis response system for persons experiencing a mental health or substance abuse crisis.



Health care for individuals with disabilities. The task force received an update on an issue concerning federal programs for individuals with disabilities. There are two primary federal programs for individuals with disabilities: Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). Individuals who qualify for SSI receive Medicaid, while individuals who qualify for SSDI receive Medicare, but only after a two-year waiting period. The presenters stated that the different eligibility requirements for the programs creates disparity among individuals with disabilities. Because the programs are administered by the federal government, the task force was limited in its ability to make changes to programs. The task force drafted a letter to Colorado's congressional delegation asking it to support legislation to eliminate the 24-month waiting period for individuals who receive SSDI to qualify for Medicare and to amend the definition of "disability" that is used to determine eligibility for the programs.

Telemedicine and home health care. The task force discussed issues related to health information technology and home health care. The task force received an update on the efforts of the Colorado Regional Health Information Organization to facilitate the exchange of health information in Colorado. The task force also received information about two programs that use telemedicine to serve clients in their homes and in rural areas of the state. Related to its discussions concerning health information technology, the task force recommends Bill B, which makes telemedicine eligible for reimbursement under the state's Medicaid program in order to comply with direction from the federal Centers for Medicare and Medicaid Services. The bill also makes technical changes related to the payment of telemedicine services.

Federal health care reform. The task force received several briefings on the status of federal health care reform legislation. The Department of Health Care Policy and Financing summarized pending federal legislation that could affect the state's health care programs, and described its efforts to participate in discussions regarding health care reform. In addition, the National Conference of State Legislatures gave the task force a detailed presentation on the provisions of several federal health care reform bills and described how the legislation could affect Medicaid and the Children's Basic Health Plan, as well as private health insurance plans regulated by the state. The task force considered, but did not recommend, a resolution that would have expressed the state's support for implementation of a single-payer health care plan.

Other health-related issues. The task force discussed a number of other health-related issues. The task force heard presentations from the Department of Health Care Policy and Financing regarding planned improvements in the eligibility determination process for, and the delivery of services in, Medicaid. The task force learned that the department has been awarded a five-year, \$42 million grant from the federal Health Resources and Services Administration to increase access to health care services and improve health outcomes for residents of the state.

The task force heard a presentation from dental providers regarding the need for dental services, and recent efforts to provide dental services to individuals who do not have dental coverage. Related to its discussion on dental issues, the task force recommends Bill G, which requires the Department of Health Care Policy and Financing to contract with a single entity for the administration of dental services provided to Medicaid clients.

The Task Force to Study Home Care Placement Agencies and Home Care Workers Placed through Home Care Placement Agencies presented its recommendations to the Health Care Task Force. The Health Care Task Force considered, but did not recommend, two bills related to home care placement agencies. One bill would have required such agencies to be licensed; another would have regulated individuals who provide in-home care.



The task force also heard a presentation regarding cosmetics and other personal care products that may contain substances that are known or suspected carcinogens. The task force considered, but did not recommend, a bill that would have banned the sale of such products in the state.

Finally, the task force considered a bill that would have allowed local governments to include specific community health elements in their master plans for long-range physical development. The bill was not recommended by the task force.

Task Force Recommendations

As a result of the task force's deliberations, the task force recommends eight bills for consideration during the 2010 legislative session.

Bill A — A Prohibition Against Consideration of Gender in Setting Rates for Individual Health Insurance Policies. Currently, health insurers may vary the premium charged to an individual who purchases coverage in the individual insurance market based on his or her gender. The bill prohibits insurance carriers from using gender as a basis for varying premium rates for individual health insurance policies and declares premium rates based on gender to be unfairly discriminatory.

Bill B — Home Health Care through Telemedicine. The bill makes telemedicine eligible for reimbursement under the state's Medicaid program in order to comply with direction from the federal Centers for Medicare and Medicaid Services. The bill makes additional changes related to reimbursement payments for telemedicine services.

Bill C — Medicaid Services that are Related to Substance Abuse. This bill adds screening, brief intervention, and referral to treatment for alcohol and other substance abuse services to the list of optional services provided under Medicaid. Screening, brief intervention, and referral services under Medicaid will not take effect until all necessary approvals under federal law and regulation have been obtained to receive federal financial participation for the costs of the services.

Bill D — Standardization of Health Insurance Information Provided to Consumers. The Commissioner of Insurance is required by the bill to adopt rules establishing standard formats for policy forms and explanation of benefit forms provided by health insurance carriers to consumers. The commissioner is required to seek input from the health insurance industry, consumers, and other stakeholders prior to adopting the rules. Carriers must comply with the standard format requirements starting July 1, 2011.

Bill E — Required Maternity Coverage for Individual Health Insurance Policies. Under the bill, health insurance carriers issuing individual sickness and accident insurance policies in Colorado are required to provide the same coverage for maternity care as is currently mandated for all group sickness and accident insurance policies. The bill also requires individual and group policies to provide coverage for pregnancy management, including contraceptive counseling, drugs, and devices. Abortion procedures and services are not required to be covered.



Bill F — Measures to Ensure the Financial Viability of the CoverColorado Program.

The bill authorizes the board of directors of the CoverColorado program to establish a schedule of fees for compensating health care providers that serve CoverColorado participants. Health care providers are prohibited from billing participants for costs in excess of the applicable fee on the fee schedule for services covered by the program. Additionally, the bill authorizes the board to maintain enrollment in the CoverColorado program consistent with the program's financial resources.

Bill G — Administration of Dental Services Provided Under Medicaid. Pursuant to Bill G, the Department of Health Care Policy and Financing is required to enter into a contract with a single entity for the administration of dental services under Medicaid. Currently, the department administers a contract with a single entity for dental services provided to children through the Children's Basic Health Plan. The contract authorized by Bill G would be distinct from that contract.

The department is not required to enter into a contract for the administration of Medicaid dental services if no suitable proposals are received by the department or if the department determines that contracting for the administration of Medicaid dental services is not cost-effective or efficient for the state, or does not result in the improvement of services provided to clients.

Bill H — Behavioral Health Crisis Response Services. The bill requires the Department of Human Services to enter into a contract with a nonprofit entity to provide initial triage services through a coordinated and integrated crisis response system for persons experiencing a mental health or substance abuse crisis. The department may contract for services including, but not limited to:

- a telephone hotline operating 24 hours per day and 7 days per week;
- an integrated information technology system to coordinate crisis response and services; and
- community-based crisis centers that provide short-term mental health services to persons in crisis.

The bill specifies requirements for the department in setting contract goals, establishing time frames for the contract, monitoring the contract, and evaluating contractor performance. The bill also requires the department to report annually to the Health and Human Services committees of the General Assembly concerning the services provided through the contract.

The department is not required to contract for the system if the system is not cost-effective for the state, if the system services are not appropriate to address the needs of persons in crisis, or if the system services may be provided in a different manner.



Task Force Charge

Pursuant to Section 10-16-221, C.R.S., the Health Care Task Force must consider a variety of issues between July 1, 2005, and July 1, 2010, that include, but are not limited to the following:

- emerging trends in Colorado health care and their impacts on consumers, including, but not limited to:
 - ▶ the effect of recent shifts in the way health care is delivered and paid for;
 - ▶ changes in relationships among health care providers, patients, and payors;
 - ▶ restrictions in health care options available to consumers;
 - ▶ professional liability issues arising from such restrictions;
 - ▶ medical and patient record confidentiality;
 - ▶ health care work force requirements; and
 - ▶ home care in the continuum of care;
- issues concerning health insurance, including:
 - ▶ the ability of consumers to obtain and keep adequate, affordable health insurance coverage, including coverage for catastrophic illnesses;
 - ▶ the effect of managed care on the ability of consumers to obtain timely access to quality care;
 - ▶ network adequacy and the adequacy of access to providers; and
 - ▶ reimbursement processes for health care services by third-party payors and cooperation between providers and carriers;
- options for addressing the needs of uninsured individuals, including the operation of the Colorado Indigent Care Program, in order to give guidance and direction to the Department of Health Care Policy and Financing in the development and operation of programs for the uninsured; and
- various other health-related topics, including:
 - ▶ costs and benefits of providing preventive care and early treatment for people with chronic illnesses who may eventually need long-term care;
 - ▶ rural health care issues;
 - ▶ certificates of need;
 - ▶ increased access to health care through the use of appropriate communication technologies, including the use of telemedicine; and
 - ▶ the establishment of a new system to reimburse emergency responders and trauma care providers for unreimbursed costs.

Bills referred to the Health Care Task Force. Since the Health Care Task Force was recreated in 2005, the General Assembly has referred a number of issues for study to the task force. A summary of legislation that has required the Health Care Task Force to study certain issues follows below.

- House Bill 06-1278 created the Colorado Hospital Report Card to allow consumers to compare the performance of hospitals through statewide reporting of hospital data and clinical outcomes. The hospital report card is available on a website administered by the Colorado Hospital Association. House Bill 08-1393, the Consumer Health Care Transparency Act, required the task force, during the 2008 interim, to study the feasibility of adding ambulatory surgical centers charges to the hospital report card.



The task force was required to study the method of reporting the appropriate data concerning ambulatory surgical centers and the time frame in which the data needs to be collected.

- House Joint Resolution 08-1031, which established the Vulnerable Population Task Force, required the Health Care Task Force to review recommendations from the Vulnerable Population Task Force concerning various issues related to health care, such as improving access and delivery of services to the disabled community, easing barriers to enrollment in public programs, and financing the CoverColorado program.
- House Bill 09-1102 required the Health Care Task Force to evaluate and make recommendations regarding the issue of portability of health insurance.
- House Bill 09-1224 required the Health Care Task Force to make recommendations on whether health insurers that issue insurance policies in the individual health insurance market should be permitted to use a person's gender as a factor in determining his or her premium.
- House Joint Resolution 09-1022 established the Task Force to Study Home Care Placement Agencies and Home Care Workers Placed through Home Care Placement Agencies and required it to evaluate ways to maintain safety and quality of life for consumers using home care placement agencies. The joint resolution permitted the task force to present its recommendations to the Health Care Task Force.

Task Force Activities

The Health Care Task Force met six times during the 2009 interim. At these hearings, the task force heard testimony from representatives of state agencies, advocacy groups, health care providers, health educators, and national organizations. The task force considered a wide variety of issues related to health care, including insurance coverage and benefits, treatment for mental health and substance abuse, health care for disabled individuals, health information technology, federal health care reform, and other issues.

Gender Rating in Health Insurance

House Bill 09-1224 required the Health Care Task Force to make recommendations concerning whether the use of gender rating in the individual insurance market should be prohibited. Gender rating is the practice of charging different rates to individuals who purchase health insurance based on their gender.

The task force heard a presentation from the National Conference on State Legislatures (NCSL) on the use of gender rating in other states. In general, in states where gender rating is permitted, women pay higher health insurance premiums than men for the same coverage, especially during child-bearing years. According to research conducted by NCSL, 10 states have enacted bans on gender rating in the individual market and 2 states limit the amount by which premiums can vary based on gender. In addition, 12 states, including Colorado, have enacted bans on the use of gender rating in the small group market. The results of a 2009 NCSL survey



on the effects of bans on gender rating were presented to the task force. The survey found that the states that have enacted bans on the use of gender rating were unable to precisely determine whether or not the bans have increased health insurance premiums in the state. In addition, the survey found that states were unable to determine whether or not health insurers have left the state as a result of enacting a gender rating ban, although one state reported that the ban did not have an effect on the number of health insurers in the state.

The task force also heard a presentation on gender rating by the National Women's Law Center. The presentation focused on the center's report *Nowhere to Turn: How the Individual Health Insurance Market Fails Women*. The report found that nationally, individual insurance coverage generally costs more for women than for men until age 55, at which point, insurance may cost more for men than for women. The center has also found the premiums vary greatly by state, and even among companies within the same state.

Additional presenters noted that coverage for maternity care can be expensive, and that insurance policies that include maternity coverage can be more expensive than policies without coverage. However, the presenters also explained that insurers are not required to offer maternity coverage to individuals who purchase individual coverage, and that individual coverage for women is often more expensive than for men, even if maternity coverage is not included.

The Health Care Task Force also heard presentations from representatives of health insurers and health insurance underwriters regarding the use of gender rating in health insurance. Presenters noted that the state Division of Insurance reviews premiums and requires that rates be actuarially sound. Furthermore, presenters explained that utilization data shows that young women access more health care services than men of the same age. Because premiums in the individual market are based upon members' anticipated use of health care, younger women are charged higher premiums than men. However, in general, men access more medical services than women later in life, and, as a result, premiums for men become more expensive than for women over time.

Task force recommendations. As a result of its discussions related to the use of gender rating in health insurance, the task force recommends Bill A. Bill A prohibits insurance carriers from using gender as a basis for varying premium rates for individual health insurance policies. The bill also declares that premium rates based on gender are unfairly discriminatory.

The task force also recommends Bill E. Bill E requires health insurers that issue individual health insurance policies to provide coverage for maternity care. The bill also requires individual and group policies to provide coverage for pregnancy management, including contraceptive counseling, drugs, and devices. Abortion procedures and services are not required to be covered.

CoverColorado

CoverColorado provides health coverage to individuals who, because of a preexisting medical condition, are unable to obtain health insurance at a reasonable cost or without significant coverage exclusions in the private market. As a result of legislation that passed in 2008, CoverColorado is funded as follows:

- 50 percent from premiums, grants, and donations, including premium tax credits;
- 25 percent from the Unclaimed Property Trust Fund, a fund that holds money from the sale of items that have been determined to have been abandoned or otherwise go unclaimed; and
- up to 25 percent from a fee levied against health insurers.



The 2008 legislation also created a task force to make recommendations for a permanent and stable long-term source of funding for CoverColorado. The task force met in 2008 and 2009, and made a variety of recommendations to improve both the short- and long-term funding situation for CoverColorado. However, since the task force met, the board of directors for CoverColorado learned that the funding for the program provided through the Unclaimed Property Trust Fund was not expected to be sustainable after 2012. As a result, the board reviewed the recommendations of the task force to determine which recommendations could be implemented in the near term to improve the financial situation for the program. The board recommended that legislation be introduced to create a schedule of fees for compensating the health care providers that serve CoverColorado patients. Representatives of the program explained that creating a fee schedule will allow the program to better manage program expenditures and control costs in the future.

Task force recommendation. As a result of its discussions concerning the CoverColorado program, the task force recommends Bill F. Bill F authorizes the CoverColorado Board of Directors to establish a fee schedule for compensating health care providers who participate in the program. Under the bill, health care providers may not bill patients for any costs in excess of the fees paid by CoverColorado.

Other Health Insurance Issues

House Bill 09-1102 required the Health Care Task Force to study and make recommendations concerning the portability of health insurance after a policyholder has been separated from employment. In general, health insurance portability refers to the ability to buy or maintain a health insurance plan despite a change in employment or geographic location. Because a majority of individuals access health insurance through their employer, they may lose coverage if they change employers or become unemployed.

The federal Health Insurance Portability and Accountability Act provides some protections for employees who have preexisting coverage to obtain health insurance coverage. In addition, states, including Colorado, have enacted laws concerning the period of time for which an insurer can refuse to cover certain preexisting conditions. The federal Consolidated Omnibus Budget Reduction Act (COBRA) also guarantees certain employees the opportunity to continue coverage through their employer's plan for up to 18 months after leaving a job. Some states, including Colorado, have extended these same protections to employees not covered by COBRA, typically employees of small employers.

The task force heard a presentation from NCSL regarding federal and state policies on health insurance portability. The presentation noted that some existing public health care coverage is portable; Medicare coverage is portable across state lines and is not tied to a specific employer. Veterans care and Medicaid can also be portable. The presentation highlighted other states' efforts to increase portability, including allowing the use of certain tax-advantaged "cafeteria" plans to purchase individual health insurance. Because individual health plans are not tied to a specific employer, the individual may keep the individual coverage even if he or she changes jobs. In addition, in 2007, Massachusetts enacted a health insurance connector. The connector is a mechanism through which both employers and individuals can purchase coverage, and can allow an individual to maintain the same coverage if he or she changes employers.

The task force also heard presentations from the Colorado Division of Insurance regarding Colorado's COBRA-related laws. In addition, the task force heard from a representative of



Mountain States Employers Council regarding COBRA and HIPPA, as well as additional COBRA coverage provided as part of the federal stimulus act, the "American Reinvestment and Recovery Act." The committee also heard from consumer advocates regarding methods to increase the portability of health insurance. Some of the options discussed included extending the state's COBRA-related law, requiring health insurers to honor decisions made by an individual's previous health insurer, allowing children to stay on their parents' health insurance plan longer, and utilizing cafeteria plans to purchase coverage. Finally, the committee heard presentations by representatives of health insurers and brokers. The presenters discussed health care reform at the federal level, and how these changes may affect the portability of health insurance for Colorado residents.

Task force recommendation. As a result of its discussions related to the portability of health insurance, and health insurance issues generally, the task force recommends Bill D. The bill requires the Commissioner of Insurance to adopt rules establishing standard formats for policy forms and explanation of benefit forms provided to consumers. The standard forms must be in place starting July 1, 2011.

Mental Health and Substance Abuse Treatment

The Health Care Task Force heard a variety of presentations related to the need for mental health and substance abuse treatment in the state. A representative of the Colorado Behavioral Health Care Council, a nonprofit organization that represents community behavioral healthcare providers, described the demand for mental health services in the state. In 2008, Colorado community mental health centers served almost 90,000 clients. The task force reviewed the recent budget cuts to services for individuals with mental health needs, and discussed how reducing services may increase the number of individuals with mental illness who become involved with the criminal justice system.

The task force also discussed issues related to substance abuse. Representatives of the Denver Office of Drug Strategy briefed the task force on its plan to institute a needle exchange program for intravenous drug users who live in Denver. The representatives noted that an estimated 4,000 intravenous drug users are believed to live in Denver. The presenters described the benefits of needle exchange programs, stating that such programs help prevent the transmission of infectious diseases.

The task force also heard a presentation regarding efforts to identify individuals who may be in danger of developing an addiction to drugs or alcohol, and refer such individuals to treatment. In 2006, Colorado received a five-year grant from the federal Substance Abuse and Mental Health Service Administration to implement the Screening, Brief Intervention, and Referral to Treatment program (SBIRT). The program's goal is to educate health care providers on how to conduct brief alcohol and drug abuse screenings during physicals and other medical interventions. Representatives of the program stated that even brief conversations about alcohol and drug abuse can make a difference in whether a person develops a drug or alcohol addiction. They noted that about 60,000 individuals have already been screened through the program.

Task force recommendations. As a result of its discussions regarding mental health and substance abuse treatment, the task force recommends two bills. Bill H requires the Department of Human Services to contract with a nonprofit organization to provide initial triage services through a crisis response system for individuals who are experiencing a mental health or substance



abuse-related emergency. The department may contract for services such as a 24-hour telephone hotline, an integrated information technology system to coordinate crisis services, and community-based crisis centers that provide short-term mental health treatment.

The task force also recommends Bill C. The bill adds SBIRT services to the list of optional services provided under Medicaid, conditional upon federal approval.

Health Care for Individuals with Disabilities

The task force was updated on an issue concerning federal programs for individuals with disabilities. There are two primary federal programs for individuals with disabilities: Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). The SSDI program provides payments to individuals who have worked and earned enough credits to become eligible for disability payments through the federal Social Security system and subsequently become disabled. The SSI program provides monthly payments to individuals who become disabled but have not worked long enough to qualify for SSDI payments. Individuals who receive SSI are automatically eligible for Medicaid; individuals who receive SSDI qualify for Medicare after a 24-month waiting period.

The presenters asserted that the different eligibility requirements for the programs creates a disparity among individuals with disabilities. Individuals who have worked and paid into the Social Security system must wait two years for health care coverage, while those who do not pay into the system are entitled to Medicaid and cash benefits immediately through the SSI program. In addition, the state may end up covering some of the costs of treating individuals eligible for SSDI if the individuals do not have other health care coverage during the 24-month waiting period for Medicare coverage.

Task force recommendation. Because the SSI and SSDI programs are administered by the federal government, the task force was limited in its ability to make changes to the programs. However, the task force drafted a letter to Colorado's congressional delegation asking them to support federal legislation to eliminate the 24-month waiting period for individuals who receive SSDI to qualify for Medicare. The letter also encouraged the Social Security Administration to explore ways to update the definition of disability that is used to determine a person's eligibility for SSI and SSDI.

Telemedicine and Home Health Care

The task force discussed several issues related to health information technology and home health care. The task force received an update on the efforts of the Colorado Regional Health Information Organization (CORHIO). CORHIO's mission is to facilitate the exchange of health information in Colorado to improve the health of all Coloradans. The organization described CORHIO's role to the task force, which is to serve as both a coordinator of health information exchange, and a broker and provider of services. The CORHIO model accommodates existing health information systems, and the organization ultimately wants to coordinate the exchange of health information across states.

The task force also received information about two programs that use telemedicine to serve clients in their homes and in rural areas of the state. Centura Health at Home told the task force



about its telemedicine pilot program for managing congestive health failure, and described how the program helped patients become independent and maintain treatment in the home. United Health Group described the Connected Care program, which partners with CISCO, Centura Health, and others to provide high-definition video and audio telehealth services. The Connected Care program is a three-year pilot program, and United Health Group described the process for selecting pilot sites and collaborating with selected clinics to implement the project. The organization also discussed obstacles to health care access in rural areas, such as distance, weather, and lack of specialists.

Task force recommendation. Related to its discussions concerning health information technology, the task force recommends Bill B, which makes telemedicine eligible for reimbursement under the state's Medicaid program in order to comply with direction from the federal Centers for Medicare and Medicaid Services. The bill also makes technical changes related to the payment of telemedicine services.

Federal Health Care Reform

The task force received several briefings on the status of federal health care reform legislation. The Department of Health Care Policy and Financing summarized pending federal legislation that could affect the state's health care programs, and described its efforts to participate in discussions regarding health care reform. The department described the major provisions of the bills pending in Congress during the summer, including common features in each bill such as establishing a standard income eligibility level for public health care programs and eliminating categorical eligibility for Medicaid. The task force discussed the concept of an individual mandate for obtaining health insurance coverage, and various witnesses described the experience of Massachusetts in implementing its state-level health reform.

In addition, the National Conference of State Legislatures gave the task force a detailed presentation on the provisions of several federal health care reform bills and described how the legislation could affect Medicaid and the Children's Basic Health Plan, as well as private health insurance plans regulated by the state. The task force also learned about other potential provisions of federal health reform legislation such as disallowing consideration of preexisting conditions, individual and employer mandates, and the creation of insurance exchanges. The task force considered, but did not recommend, a resolution that would have expressed the state's support for implementation of a single-payer health care plan.

Other Health-related Issues

Throughout the interim, the task force discussed a number of other health-related issues, including: Medicaid eligibility; dental services; the recommendations of the Task Force to Study Home Care Placement Agencies and Home Care Workers Placed through Home Care Placement Agencies; personal care products that contain known or suspected carcinogens; and local government master plans.

Medicaid eligibility. The task force heard presentations from the Department of Health Care Policy and Financing regarding planned improvements in the eligibility determination process for, and the delivery of services in, Medicaid. The task force learned that the department has been awarded a five-year, \$42 million grant from the federal Health Resources and Services



Administration to increase access to health care services and improve health outcomes for residents of the state. A portion of the grant will be used to implement the Colorado Health Care Affordability Act, a bill passed in 2009 that increases eligibility for Medicaid and the Children's Basic Health Plan, by beginning various initiatives, such as an outreach retention program for new Medicaid populations.

Dental services. The task force heard a presentation from dental providers regarding the need for dental services, and recent efforts to provide dental services to individuals who do not have dental coverage. The dental providers described the Colorado Mission of Mercy (COMOM), which was a 2-day, 100-chair, dental clinic that provided free dental care to about 1,600 individuals in Colorado. The dental providers discussed federal health reform legislation and efforts to increase Medicaid dental provider reimbursement rates. The task force also learned that 18 counties in Colorado have no Medicaid dental provider. Related to its discussion on dental issues, the task force recommends Bill G, which requires the Department of Health Care Policy and Financing to contract with a single entity for the administration of dental services provided to Medicaid clients.

Home care placement agencies and home care workers. The Task Force to Study Home Care Placement Agencies and Home Care Workers Placed through Home Care Placement Agencies presented its recommendations to the Health Care Task Force. The committee heard testimony from proponents and opponents of licensing home care placement agencies. Proponents told the task force that there needs to be regulation in order to protect seniors and others receiving care. Opponents stated that licensure of home care placement agencies would provide a false sense of security because the placement agencies have no direct control over the independent contractors that a family may hire through a placement agency. The Health Care Task Force considered, but did not recommend, two bills related to home care placement agencies. One bill would have required such agencies to be licensed; another would have regulated individuals who provide in-home care.

Cosmetic products. The task force also heard a presentation regarding cosmetics and other personal care products that may contain substances that are known or suspected carcinogens. The witnesses described how citizens can look up information about chemicals contained in common personal care and cosmetic products. The task force discussed the role of the state in protecting consumers from potentially unsafe products and the need for individual responsibility in purchasing products. The task force discussed labeling requirements for personal care and cosmetic products, and talked about the role of the states and the federal government in regulating the contents of products and labeling requirements. The task force considered, but did not recommend, a bill that would have banned the sale of such products in the state.

Local government master plans. Finally, the task force considered a bill that would have allowed local governments to include specific community health elements in their master plans for long-range physical development. The bill was not recommended by the task force.



Summary of Recommendations

As a result of the task force's deliberations, the task force recommends eight bills for consideration during the 2010 legislative session.

Bill A — A Prohibition Against Consideration of Gender in Setting Rates for Individual Health Insurance Policies

Bill A prohibits insurance carriers from using gender as a basis for varying premium rates for individual health insurance policies and declares premium rates based on gender to be unfairly discriminatory. Currently, health insurers may vary the premium charged to an individual who purchases coverage in the individual insurance market based on his or her gender.

Bill B — Home Health Care through Telemedicine

Bill B makes telemedicine eligible for reimbursement under the state's Medicaid program in order to comply with direction from the federal Centers for Medicare and Medicaid Services. The bill makes additional changes related to reimbursement payments for telemedicine services, and clarifies language regarding the use of cost savings that may result from the use of telemedicine.

Bill C — Medicaid Services that are Related to Substance Abuse

Bill C adds screening, brief intervention, and referral to treatment for alcohol and other substance abuse services to the list of optional services provided under Medicaid. Screening, brief intervention, and referral services under Medicaid will not take effect until all necessary approvals under federal law and regulation have been obtained to receive federal financial participation for the costs of the services.

Bill D — Standardization of Health Insurance Information Provided to Consumers

Under Bill D, the Commissioner of Insurance is required to adopt rules establishing standard formats for policy forms and explanation of benefit forms provided by health insurance carriers to consumers. The commissioner is required to seek input from the health insurance industry, consumers, and other stakeholders prior to adopting the rules. Carriers must comply with the standard format requirements starting July 1, 2011.

Bill E — Required Maternity Coverage for Individual Health Insurance Policies

Under Bill E, health insurance carriers issuing individual sickness and accident insurance policies in Colorado are required to provide the same coverage for maternity care as is currently mandated for all group sickness and accident insurance policies. The bill also requires individual and group policies to provide coverage for pregnancy management, including contraceptive counseling, drugs, and devices. Abortion procedures and services are not required to be covered.



Bill F — Measures to Ensure the Financial Viability of the CoverColorado Program

Bill F authorizes the board of directors of the CoverColorado program to establish a schedule of fees for compensating health care providers that serve CoverColorado participants. Health care providers are prohibited from billing participants for costs in excess of the applicable fee on the fee schedule for services covered by the program. The fee schedule takes effect no sooner than January 1, 2011. Additionally, the bill authorizes the board to maintain enrollment in the CoverColorado program consistent with the program's financial resources.

Bill G — Administration of Dental Services Provided Under Medicaid

Bill G requires the Department of Health Care Policy and Financing to enter into a contract with a single entity for the administration of dental services under Medicaid. Currently, the department administers a contract with a single entity for dental services provided to children through the Children's Basic Health Plan. The contract authorized by Bill G would be distinct from that contract. The bill specifies that contract must prohibit the contracting entity 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.

The department is not required to enter into a contract for the administration of Medicaid dental services if no suitable proposals are received by the department or if the department determines that contracting for the administration of Medicaid dental services is not cost-effective or efficient for the state, or does not result in the improvement of services provided to clients.

Bill H — Behavioral Health Crisis Response Services

Bill H requires the Department of Human Services to enter into a contract with a nonprofit entity to provide initial triage services through a coordinated and integrated crisis response system for persons experiencing mental health or substance abuse crisis. The department may contract for services including, but not limited to:

- a telephone hotline operating 24 hours per day and 7 days per week;
- an integrated information technology system to coordinate crisis response and services; and
- community-based crisis centers that provide short-term mental health services to persons in crisis.

The bill specifies requirements for the department in setting contract goals, establishing time frames for the contract, monitoring the contract, and evaluating contractor performance. The bill also requires the department to report annually to the Health and Human Services committees of the General Assembly concerning the services provided through the contract.

The department is not required to contract for the system if the system is not cost-effective for the state, if the system services are not appropriate to address the needs of persons in crisis, or if the system services may be provided in a different manner.



Resource Materials

Meeting summaries are prepared for each meeting of the committee and contain all handouts provided to the committee. The summaries of meetings and attachments are available at the Division of Archives, 1313 Sherman Street, Denver (303-866-4900). The listing below contains the dates of committee meetings and the topics discussed at those meetings. Meeting summaries are also available on our website at:

<http://www.colorado.gov/lcs/HCTF>

Meeting Date and Topics Discussed

July 9, 2009

- ◆ Update from the Colorado Department of Health Care Policy and Financing
- ◆ Update from Colorado Regional Health Information Organization
- ◆ Rural health in Colorado
- ◆ Presentation of the Prevention First Report

August 10, 2009

- ◆ Behavioral health in Colorado
- ◆ Screening, Brief Intervention, and Referral to Treatment Program
- ◆ Portability of health insurance (House Bill 09-1102)
- ◆ Gender rating in health insurance (House Bill 09-1224)
- ◆ Overview of the University of Colorado's Academic Medical Center

August 11, 2009

- ◆ CoverColorado
- ◆ The Colorado Health Institute's Center for Study of the Safety Net and Health Professions Project
- ◆ Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI)
- ◆ Federally qualified health centers
- ◆ Transparency in pharmacy benefits
- ◆ Patient safety
- ◆ Safe cosmetics

August 31, 2009

- ◆ Federal health care reform
- ◆ Health care reform in Colorado
- ◆ Presentation of the Health Care Affordability Study



August 31, 2009 (Cont.)

- ◆ Telemedicine
- ◆ Denver Drug Strategy Plan
- ◆ Chronic Care Collaborative

September 14, 2009

- ◆ All Kids Covered by 2010
- ◆ Overview of dental issues by the Colorado Dental Association
- ◆ Updated on H1N1 preparations
- ◆ Recommendations from the Task Force to Study Home Care Placement Agencies and Home Care Workers
- ◆ Recommendations for long-term funding for CoverColorado
- ◆ Discussion of potential draft legislation

October 19, 2009

- ◆ Presentation of the Limited English Proficiency Report
- ◆ Issues related to ambulatory surgery centers
- ◆ Medicaid eligibility modernization
- ◆ Medical food coverage
- ◆ Presentation from the Colorado Regional Integrated Care Collaborative
- ◆ Discussion and approval of proposed committee legislation



Second Regular Session
Sixty-seventh General Assembly
STATE OF COLORADO

BILL A

LLS NO. 10-0158.01 Christy Chase

HOUSE BILL

HOUSE SPONSORSHIP

Schafer S. and McCann, Apuan, Frangas, Massey

SENATE SPONSORSHIP

Carroll M. and Schwartz, Boyd, Foster

House Committees

Senate Committees

A BILL FOR AN ACT

101 **CONCERNING A PROHIBITION AGAINST CONSIDERATION OF GENDER IN**
102 **SETTING RATES FOR INDIVIDUAL HEALTH INSURANCE POLICIES.**

Bill Summary

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

Health Care Task Force. The bill prohibits carriers from using gender as a basis for varying premium rates for individual health insurance policies and declares premium rates based on gender to be unfairly discriminatory.

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

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

1 **SECTION 1.** 10-16-107 (1.5), Colorado Revised Statutes, is
2 amended to read:

3 **10-16-107. Rate regulation - rules - approval of policy forms**
4 **- benefit certificates - evidences of coverage - benefits ratio -**
5 **disclosures on treatment of intractable pain.** (1.5) (a) Rates for an
6 individual sickness, accident, or health insurance policy, contract,
7 certificate, or other evidence of coverage issued or delivered to any
8 policyholder, enrollee, subscriber, or member in Colorado by an insurer
9 subject to ~~the provisions of~~ part 2 of this article or an entity subject to ~~the~~
10 ~~provisions of~~ part 3 or 4 of this article shall not be excessive, inadequate,
11 or unfairly discriminatory to assure compliance with the requirements of
12 this section that rates are not excessive in relation to benefits. Rates are
13 excessive if they are likely to produce a long run profit that is
14 unreasonably high for the insurance provided or if expenses are
15 unreasonably high in relation to services rendered. In determining if rates
16 are excessive, the commissioner may consider the expected filed rates in
17 relation to the actual rates charged. Concerning inadequacy, rates are not
18 inadequate unless clearly insufficient to sustain projected losses and
19 expenses, or the use of such rates, if continued, will tend to create a
20 monopoly in the market. Concerning unfair discrimination, unfair
21 discrimination exists if, after allowing for practical limitations, price
22 differentials fail to reflect equitably the differences in expected losses and
23 expenses.

24 (b) NOTWITHSTANDING ANY OTHER PROVISION OF THIS ARTICLE,
25 AN INSURER SUBJECT TO PART 2 OF THIS ARTICLE OR AN ENTITY SUBJECT
26 TO PART 3 OR 4 OF THIS ARTICLE SHALL NOT VARY THE PREMIUM RATE FOR
27 AN INDIVIDUAL SICKNESS, ACCIDENT, OR HEALTH INSURANCE POLICY,

1 CONTRACT, CERTIFICATE, OR OTHER EVIDENCE OF COVERAGE DUE TO THE
2 GENDER OF THE INDIVIDUAL POLICYHOLDER, ENROLLEE, SUBSCRIBER, OR
3 MEMBER. ANY PREMIUM RATE BASED ON THE GENDER OF THE INDIVIDUAL
4 POLICYHOLDER, ENROLLEE, SUBSCRIBER, OR MEMBER SHALL BE
5 CONSIDERED UNFAIRLY DISCRIMINATORY AND SHALL NOT BE ALLOWED.

6 **SECTION 2. Act subject to petition - effective date -**
7 **applicability.** (1) This act shall take effect at 12:01 a.m. on the day
8 following the expiration of the ninety-day period after final adjournment
9 of the general assembly (August 11, 2010, if adjournment sine die is on
10 May 12, 2010); except that, if a referendum petition is filed pursuant to
11 section 1 (3) of article V of the state constitution against this act or an
12 item, section, or part of this act within such period, then the act, item,
13 section, or part shall not take effect unless approved by the people at the
14 general election to be held in November 2010 and shall take effect on the
15 date of the official declaration of the vote thereon by the governor.

16 (2) The provisions of this act shall apply to rates for individual
17 sickness, accident, or health insurance policies, contracts, certificates, or
18 other evidence of coverage set on or after the applicable effective date of
19 this act.

Second Regular Session
Sixty-seventh General Assembly
STATE OF COLORADO

BILL B

LLS NO. 10-0159.01 Kristen Forrestal

HOUSE BILL

HOUSE SPONSORSHIP

Massey, Frangas, Kerr J., McCann

SENATE SPONSORSHIP

Foster, Boyd, Lundberg, Schwartz

House Committees

Senate Committees

A BILL FOR AN ACT

101 **CONCERNING HOME HEALTH CARE THROUGH TELEMEDICINE**
102 **PURSUANT TO THE "COLORADO MEDICAL ASSISTANCE ACT".**

Bill Summary

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

Health Care Task Force. This bill makes telemedicine eligible for reimbursement under the state's medical assistance program (program) in order to comply with direction from the federal centers for medicare and medicaid services.

Eliminates incorrect references to the way reimbursement payments are made under the program.

Deletes the requirement that reimbursement rates from telemedicine be budget neutral or result in cost savings to the program.

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.

Capital letters indicate new material to be added to existing statute.

Dashes through the words indicate deletions from existing statute.

Requires that any cost savings identified be considered for use in paying for home health care or home- and community-based services instead of requiring the savings be applied to payment for the services.

Deletes the requirement that the state medical services board consider reductions in travel costs by home health care or home- and community-based service providers and other factors when setting reimbursement rates for services.

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

2 **SECTION 1.** 25.5-5-321 (1), (2), and (3), Colorado Revised
3 Statutes, are amended to read:

4 **25.5-5-321. Telemedicine - home health care - rules.** (1) On or
5 after January 1, 2008, ~~in-person contact between a home health care or a~~
6 ~~home- and community-based services provider and a patient shall not be~~
7 ~~required under the state's medical assistance program for home health~~
8 ~~care services or home- and community-based services delivered through~~
9 ~~telemedicine that are otherwise eligible for reimbursement under the~~
10 ~~program. This program shall include health care professional oversight~~
11 ~~and intervention as appropriate~~ THE EFFECTIVE DATE OF THIS SUBSECTION

12 (1), AS AMENDED, AT-HOME TELEMEDICINE SHALL BE ELIGIBLE FOR
13 REIMBURSEMENT UNDER THE STATE'S MEDICAL ASSISTANCE PROGRAM.

14 The services delivered through telemedicine shall be subject to
15 reimbursement policies promulgated by rule of the state board after
16 consultation with home health care and home- and community-based
17 services providers. This section also applies to managed care
18 organizations that contract with the state department pursuant to the
19 statewide managed care system, but only to the extent that:

20 (a) Home health care or home- and community-based services
21 delivered through telemedicine are covered by and reimbursed under the
22 medicaid ~~per diem payment~~ program; and

1 (b) Managed care contracts with managed care organizations are
2 amended to add coverage of home health care or home- and
3 community-based services delivered through telemedicine. ~~and any~~
4 ~~appropriate per diem rate adjustments are incorporated.~~

5 (2) (a) The reimbursement rate for home health care or home- and
6 community-based services delivered through telemedicine that are
7 otherwise eligible for reimbursement under the medical assistance
8 program shall be set by rule of the state board and shall be:

9 (I) In the form of a flat fee ~~per month~~ in one or more levels,
10 depending on acuity. ~~and~~

11 (II) ~~Budget-neutral or result in cost savings to the program.~~

12 (b) Any cost savings identified pursuant to this section shall be
13 ~~made available~~ CONSIDERED for use in paying for home- and
14 community-based services under part 6 of this article, community-based
15 long-term care, and home health services.

16 (3) ~~When setting the reimbursement rate for services under~~
17 ~~subsection (2) of this section, the state board shall consider, to the extent~~
18 ~~applicable, reductions in travel costs by home health care or home- and~~
19 ~~community-based services providers to deliver the services and such other~~
20 ~~factors as the state department deems relevant.~~ Reimbursement shall not
21 be provided for purchase or lease of telemedicine equipment.

22 **SECTION 2. Act subject to petition - effective date.** This act
23 shall take effect at 12:01 a.m. on the day following the expiration of the
24 ninety-day period after final adjournment of the general assembly (August
25 11, 2010, if adjournment sine die is on May 12, 2010); except that, if a
26 referendum petition is filed pursuant to section 1 (3) of article V of the
27 state constitution against this act or an item, section, or part of this act

1 within such period, then the act, item, section, or part shall not take effect
2 unless approved by the people at the general election to be held in
3 November 2010 and shall take effect on the date of the official
4 declaration of the vote thereon by the governor.

Second Regular Session
Sixty-seventh General Assembly
STATE OF COLORADO

BILL C

LLS NO. 10-0160.01 Jerry Barry

HOUSE BILL

HOUSE SPONSORSHIP

Massey, Frangas, Kerr J., McCann

SENATE SPONSORSHIP

Boyd and Schwartz, Foster

House Committees

Senate Committees

A BILL FOR AN ACT

101 **CONCERNING THE PROVISION OF SERVICES THROUGH THE MEDICAID**
102 **PROGRAM THAT ARE RELATED TO SUBSTANCE ABUSE.**

Bill Summary

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

Health Care Task Force. Adds to the list of optional services provided to medicaid recipients screening, brief intervention, and referral to treatment for alcohol and other substance abuse services.

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

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

1 **SECTION 1.** 25.5-5-202 (1), Colorado Revised Statutes, is
2 amended BY THE ADDITION OF A NEW PARAGRAPH to read:

3 **25.5-5-202. Basic services for the categorically needy - optional**
4 **services - repeal.** (1) Subject to the provisions of subsection (2) of this
5 section, the following are services for which federal financial
6 participation is available and which Colorado has selected to provide as
7 optional services under the medical assistance program:

8 (u) (I) SCREENING, BRIEF INTERVENTION, AND REFERRAL TO
9 TREATMENT FOR INDIVIDUALS AT RISK OF SUBSTANCE ABUSE, INCLUDING
10 REFERRAL TO THE APPROPRIATE LEVEL OF INTERVENTION AND
11 TREATMENT.

12 (II) NOTWITHSTANDING THE PROVISIONS OF SUBPARAGRAPH (I) OF
13 THIS PARAGRAPH (u), SERVICES RELATING TO SCREENING, BRIEF
14 INTERVENTION, AND REFERRAL TO TREATMENT SHALL NOT TAKE EFFECT
15 UNLESS ALL NECESSARY APPROVALS UNDER FEDERAL LAW AND
16 REGULATION HAVE BEEN OBTAINED TO RECEIVE FEDERAL FINANCIAL
17 PARTICIPATION FOR THE COSTS OF SUCH SERVICES.

18 **SECTION 2. Act subject to petition - effective date.** This act
19 shall take effect at 12:01 a.m. on the day following the expiration of the
20 ninety-day period after final adjournment of the general assembly (August
21 11, 2010, if adjournment sine die is on May 12, 2010); except that, if a
22 referendum petition is filed pursuant to section 1 (3) of article V of the
23 state constitution against this act or an item, section, or part of this act
24 within such period, then the act, item, section, or part shall not take effect
25 unless approved by the people at the general election to be held in
26 November 2010 and shall take effect on the date of the official
27 declaration of the vote thereon by the governor.

Second Regular Session
Sixty-seventh General Assembly
STATE OF COLORADO

BILL D

LLS NO. 10-0161.01 Christy Chase

HOUSE BILL

HOUSE SPONSORSHIP

Massey, Apuan, Frangas, Kerr J.

SENATE SPONSORSHIP

Foster, Boyd, Schwartz

House Committees

Senate Committees

A BILL FOR AN ACT

101 **CONCERNING STANDARDIZATION OF HEALTH INSURANCE**
102 **INFORMATION PROVIDED TO CONSUMERS.**

Bill Summary

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

Health Care Task Force. The bill requires the commissioner of insurance (commissioner) to adopt rules establishing standard formats for policy forms and explanation of benefit forms provided by health insurance carriers to consumers. The bill obligates the commissioner to seek input from the health insurance industry, consumers, and other stakeholders prior to adopting the rules. The bill requires carriers to comply with the standard format requirements starting July 1, 2011.

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

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

2 **SECTION 1.** Part 1 of article 16 of title 10, Colorado Revised
3 Statutes, is amended BY THE ADDITION OF A NEW SECTION to
4 read:

5 **10-16-137. Policy forms - explanation of benefits -**
6 **standardization of forms - rules.** (1) THE COMMISSIONER SHALL ADOPT
7 RULES ESTABLISHING A STANDARD FORMAT FOR CARRIERS TO USE FOR
8 POLICY FORMS ISSUED OR DELIVERED IN THIS STATE THAT DESCRIBE THE
9 CONTENTS AND COVERAGE UNDER A HEALTH BENEFIT PLAN, LIMITED
10 BENEFIT HEALTH INSURANCE, OR A DENTAL PLAN. THE POLICY FORMS
11 SHALL BE STANDARDIZED ACCORDING TO SECTION NAMES AND THE
12 PLACEMENT OF THOSE SECTIONS IN THE POLICY FORMS ISSUED BY ALL
13 CARRIERS. PRIOR TO ADOPTING THE RULES, THE COMMISSIONER SHALL
14 SEEK INPUT FROM CARRIERS, CONSUMERS, AND OTHER STAKEHOLDERS IN
15 DEVELOPING THE STANDARDIZED FORMAT FOR POLICY FORMS. THE RULES
16 SHALL APPLY TO HEALTH BENEFIT PLANS, LIMITED BENEFIT HEALTH
17 INSURANCE, AND DENTAL PLANS ISSUED, RENEWED, OR DELIVERED ON OR
18 AFTER JULY 1, 2011.

19 (2) THE COMMISSIONER SHALL ADOPT RULES ESTABLISHING A
20 STANDARD FORMAT FOR CARRIERS TO USE FOR AN EXPLANATION OF
21 BENEFITS FORM SENT TO COVERED PERSONS MAKING A CLAIM FOR
22 COVERED BENEFITS UNDER A HEALTH BENEFIT PLAN, LIMITED BENEFIT
23 HEALTH INSURANCE, OR A DENTAL PLAN. PRIOR TO ADOPTING THE RULES,
24 THE COMMISSIONER SHALL SEEK INPUT FROM CARRIERS, CONSUMERS, AND
25 OTHER STAKEHOLDERS IN DEVELOPING THE STANDARDIZED FORMAT FOR
26 EXPLANATION OF BENEFIT FORMS. THE RULES SHALL APPLY TO

1 EXPLANATION OF BENEFIT FORMS PERTAINING TO CLAIMS FOR BENEFITS
2 UNDER HEALTH BENEFIT PLANS, LIMITED BENEFIT HEALTH INSURANCE,
3 AND DENTAL PLANS, SUBMITTED ON OR AFTER JULY 1, 2011.

4 **SECTION 2. Act subject to petition - effective date.** This act
5 shall take effect at 12:01 a.m. on the day following the expiration of the
6 ninety-day period after final adjournment of the general assembly (August
7 11, 2010, if adjournment sine die is on May 12, 2010); except that, if a
8 referendum petition is filed pursuant to section 1 (3) of article V of the
9 state constitution against this act or an item, section, or part of this act
10 within such period, then the act, item, section, or part shall not take effect
11 unless approved by the people at the general election to be held in
12 November 2010 and shall take effect on the date of the official
13 declaration of the vote thereon by the governor.

Second Regular Session
Sixty-seventh General Assembly
STATE OF COLORADO

BILL E

LLS NO. 10-0162.01 Kristen Forrestal

HOUSE BILL

HOUSE SPONSORSHIP

Frangas and McCann,

SENATE SPONSORSHIP

Foster, Boyd

House Committees

Senate Committees

A BILL FOR AN ACT

101 **CONCERNING REQUIRED COVERAGES FOR REPRODUCTIVE SERVICES**
102 **FOR HEALTH INSURANCE POLICIES.**

Bill Summary

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

Health Care Task Force. The bill requires entities issuing individual sickness and accident insurance policies in this state to provide the same coverage for maternity care as is currently mandated for all group sickness and accident insurance policies. The bill also requires both individual and group policies to provide coverage for pregnancy management, including contraceptive counseling, drugs, and devices. The bill excludes abortion procedures and services from pregnancy

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

management.

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

2 **SECTION 1.** 10-16-104 (3) (a) (I), Colorado Revised Statutes, is
3 amended to read:

4 **10-16-104. Mandatory coverage provisions - definitions.**

5 (3) **Maternity coverage.** (a) (I) All group sickness and accident
6 insurance policies providing coverage within the state and issued to an
7 employer by an entity subject to ~~the provisions of~~ part 2 of this article,
8 ~~and~~ all group health service contracts issued by an entity subject to ~~the~~
9 ~~provisions of~~ part 3 or 4 of this article and issued to an employer, AND
10 ALL INDIVIDUAL SICKNESS AND ACCIDENT INSURANCE POLICIES ISSUED BY
11 AN ENTITY SUBJECT TO PART 2 OF THIS ARTICLE shall insure against the
12 expense of normal pregnancy and childbirth or provide coverage for
13 maternity care ~~therefor~~ AND PROVIDE COVERAGE FOR PREGNANCY
14 MANAGEMENT, INCLUDING, BUT NOT LIMITED TO, CONTRACEPTIVE
15 COUNSELING, DRUGS, AND DEVICES in the same manner as any other
16 sickness, injury, disease, or condition is otherwise covered under the
17 policy or contract. Policies or contracts shall not exclude coverage for
18 pregnancy and delivery expenses on the grounds that pregnancy was a
19 preexisting condition. NOTHING IN THIS SUBPARAGRAPH (I) SHALL BE
20 INTERPRETED TO MANDATE COVERAGE FOR ABORTION PROCEDURES OR
21 SERVICES.

22 **SECTION 2. Act subject to petition - specified effective date**
23 **- applicability.** (1) This act shall take effect January 1, 2011; except
24 that, if a referendum petition is filed pursuant to section 1 (3) of article V
25 of the state constitution against this act or an item, section, or part of this

1 act within the ninety-day period after final adjournment of the general
2 assembly, then the act, item, section, or part shall not take effect unless
3 approved by the people at the general election to be held in November,
4 2010, and shall take effect on January 1, 2011, or on the date of the
5 official declaration of the vote thereon by the governor, whichever is
6 later.

7 (2) The provisions of this act shall apply to individual sickness
8 and accident insurance policies issued or renewed on or after the
9 applicable effective date of this act.

**Second Regular Session
Sixty-seventh General Assembly
STATE OF COLORADO**

BILL F

LLS NO. 10-0166.01 Christy Chase

SENATE BILL

SENATE SPONSORSHIP

Boyd, Foster, Schwartz

HOUSE SPONSORSHIP

Massey, Apuan

Senate Committees

House Committees

A BILL FOR AN ACT

101 **CONCERNING MEASURES TO ADDRESS THE FINANCIAL VIABILITY OF**
102 **THE COVERCOLORADO PROGRAM.**

Bill Summary

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

Health Care Task Force. The bill authorizes the board of directors (board) of the CoverColorado program to establish a schedule of fees for compensating health care providers that render covered health care services to CoverColorado participants. The bill also prohibits health care providers from billing participants for costs in excess of the applicable fee on the fee schedule for services covered by the program.

Additionally, the bill authorizes the board to maintain enrollment

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

in the CoverColorado program consistent with the program's financial resources.

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

2 **SECTION 1.** 10-8-506 (1) (m), Colorado Revised Statutes, is
3 amended, and the said 10-8-506 (1) is further amended BY THE
4 ADDITION OF THE FOLLOWING NEW PARAGRAPHS, to read:

5 **10-8-506. Board - powers and duties.** (1) The board shall be
6 the governing body of the program and shall have all powers necessary
7 to implement the provisions of this part 5. In addition, the board shall
8 have the specific authority to:

9 (m) Establish procedures for the reasonable advance notice to
10 interested parties of the agenda for meetings of the board; ~~and~~

11 (o) ESTABLISH ONE OR MORE FEE SCHEDULES, IN ACCORDANCE
12 WITH SECTION 10-8-512.5, SETTING THE AMOUNT THAT ALL MEDICAL,
13 SURGICAL, HOSPITAL, AND OTHER HEALTH CARE SERVICE PROVIDERS WILL
14 BE COMPENSATED BY THE PROGRAM FOR PROVIDING SERVICES COVERED
15 BY THE PROGRAM TO A COVERCOLORADO PARTICIPANT; AND

16 (p) MAINTAIN ENROLLMENT CONSISTENT WITH AND WITHIN THE
17 AVAILABLE FINANCIAL RESOURCES OF THE PROGRAM, IN ACCORDANCE
18 WITH CRITERIA AND PROCEDURES ESTABLISHED BY THE BOARD AND
19 SUBJECT TO APPLICABLE FEDERAL LAW.

20 **SECTION 2.** Part 5 of article 8 of title 10, Colorado Revised
21 Statutes, is amended BY THE ADDITION OF A NEW SECTION to
22 read:

23 **10-8-512.5. Fee schedule - compensation of health care**
24 **providers - rules.** (1) (a) THE BOARD MAY ESTABLISH ONE OR MORE FEE
25 SCHEDULES SETTING THE AMOUNT THAT THE PROGRAM WILL COMPENSATE

1 ALL MEDICAL, SURGICAL, HOSPITAL, AND OTHER HEALTH CARE SERVICE
2 PROVIDERS WHO PROVIDE SERVICES COVERED BY THE PROGRAM TO A
3 COVERCOLORADO PARTICIPANT. IN DEVELOPING A FEE SCHEDULE
4 PURSUANT TO THIS SECTION, THE BOARD SHALL CONSIDER AT LEAST THE
5 FOLLOWING FACTORS:

6 (I) THE COSTS SAVINGS TO THE PROGRAM;

7 (II) THE EQUITY OF THE FEE SCHEDULE FOR PROVIDERS; AND

8 (III) THE IMPACT A FEE SCHEDULE MAY HAVE ON THE COST SHIFT
9 TO OTHER PAYERS.

10 (b) IF A FEE SCHEDULE IS ESTABLISHED PURSUANT TO THIS
11 SECTION, THE BOARD SHALL REVIEW THE FEE SCHEDULE ANNUALLY TO
12 DETERMINE WHETHER MODIFICATIONS ARE NEEDED AND SHALL OBTAIN
13 INPUT FROM PROVIDERS REGARDING WHETHER AND WHAT MODIFICATIONS
14 ARE NEEDED.

15 (c) ANY FEE SCHEDULE ESTABLISHED PURSUANT TO THIS SECTION
16 SHALL TAKE EFFECT NO SOONER THAN JANUARY 1, 2011, OR ON SUCH
17 LATER DATE AS DETERMINED BY THE BOARD.

18 (2) (a) EXCEPT AS OTHERWISE PROVIDED IN RULES OF THE
19 COMMISSIONER, A HEALTH CARE PROVIDER, HEALTH CARE FACILITY,
20 EMERGENCY SERVICE PROVIDER, OR OTHER PERSON OR ENTITY PROVIDING
21 HEALTH CARE SERVICES TO A PARTICIPANT SHALL NOT CONTRACT WITH,
22 BILL, OR CHARGE A PARTICIPANT OR THE PROGRAM A FEE FOR SERVICES
23 COVERED BY THE PROGRAM THAT IS IN EXCESS OF THE APPLICABLE FEE ON
24 A FEE SCHEDULE ESTABLISHED PURSUANT TO THIS SECTION. ANY BILL OR
25 CHARGE FOR SERVICES COVERED BY THE PROGRAM THAT IS IN EXCESS OF
26 THE APPLICABLE FEE ON THE FEE SCHEDULE SHALL BE UNLAWFUL, VOID,
27 AND UNENFORCEABLE AS A DEBT.

1 (b) NOTHING IN THIS SUBSECTION (2) SHALL PRECLUDE A HEALTH
2 CARE PROVIDER, HEALTH CARE FACILITY, EMERGENCY SERVICE PROVIDER,
3 OR OTHER PERSON OR ENTITY PROVIDING HEALTH CARE SERVICES TO A
4 PARTICIPANT FROM BILLING OR CHARGING A PARTICIPANT FOR APPLICABLE
5 COINSURANCE, DEDUCTIBLE, OR COPAYMENT AMOUNTS OR FOR SERVICES
6 NOT COVERED BY THE PROGRAM.

7 (3) THE COMMISSIONER SHALL ADOPT RULES AS NECESSARY TO
8 IMPLEMENT THIS SECTION, WHICH RULES SHALL INCLUDE ANY FEE
9 SCHEDULE ESTABLISHED OR MODIFIED BY THE BOARD.

10 **SECTION 3.** 10-8-526, Colorado Revised Statutes, is amended
11 to read:

12 **10-8-526. Expenses covered.** Health benefit plans issued
13 pursuant to this part 5 shall cover expenses incurred for health care
14 services or articles or items related to such services or articles that are
15 medically necessary, subject to the cost containment controls authorized
16 by this part 5; except that such coverage shall not extend to costs for such
17 services or articles over and above ~~the reasonable and customary charge~~
18 ~~in the locality~~ ANY SCHEDULE OF FEES ESTABLISHED PURSUANT TO
19 SECTION 10-8-512.5 and shall not extend to services or articles that are
20 not prescribed by a physician who is licensed to practice in the state or
21 jurisdiction where such services or articles are provided. Such services
22 shall include but not be limited to care for acute illnesses and ongoing
23 care for the treatment of the insured's uninsurable condition. Coverage
24 under a health benefit plan shall be at least comparable to that issued on
25 a group basis in the market.

26 **SECTION 4. Effective date.** This act shall take effect July 1,
27 2010.

1 **SECTION 5. Safety clause.** The general assembly hereby finds,
2 determines, and declares that this act is necessary for the immediate
3 preservation of the public peace, health, and safety.

Second Regular Session
Sixty-seventh General Assembly
STATE OF COLORADO

BILL G

LLS NO. 10-0169.01 Brita Darling

HOUSE BILL

HOUSE SPONSORSHIP

McCann, Apuan, Massey

SENATE SPONSORSHIP

Foster and Schwartz, Boyd

House Committees

Senate Committees

A BILL FOR AN ACT

101 **CONCERNING THE ADMINISTRATION OF DENTAL SERVICES PROVIDED**
102 **UNDER MEDICAID.**

Bill Summary

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

Health Care Task Force. This bill requires the department of health care policy and financing (department) to enter into a contract with a single entity for the administration of dental services under medicaid (medicaid dental services). Medicaid dental services are primarily provided to children and are distinct from the dental services provided under the children's basic health plan that is currently administered by a single entity.

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

The bill requires the department to monitor the contract for compliance and performance. The contracting entity will be required to provide any data and information necessary for the department to monitor and evaluate the contracting entity's performance.

The department is not required to enter into a contract for the administration of medicaid dental services if no suitable proposals are received by the department or if the department determines that contracting for the administration of medicaid dental services is not cost-effective or efficient for the state or does not result in the improvement of services provided to clients.

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

SECTION 1. Part 2 of article 4 of title 25.5, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

25.5-4-211. Administration of dental services. (1) AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES, "DENTAL PROVIDER" MEANS A LICENSED PROFESSIONAL WHO PROVIDES COVERED DENTAL SERVICES PURSUANT TO THIS ARTICLE AND ARTICLES 5 AND 6 OF THIS TITLE.

(2) (a) THE STATE DEPARTMENT SHALL CONTRACT WITH A SINGLE, QUALIFIED ENTITY FOR THE ADMINISTRATION OF DENTAL SERVICES PURSUANT TO SECTION 25.5-5-102 (1) (d) AND (1) (g), THAT WILL RESULT IN GREATER EFFICIENCY TO THE STATE AND WILL FACILITATE BETTER ACCESS FOR BOTH CLIENTS AND DENTAL PROVIDERS. THE CONTRACT SHALL BE AWARDED THROUGH A COMPETITIVE BIDDING PROCESS IN ACCORDANCE WITH THE "PROCUREMENT CODE", ARTICLES 101 TO 112 OF TITLE 24, C.R.S.

(b) THE CONTRACT SHALL SPECIFICALLY PROVIDE THAT THE CONTRACTING ENTITY IS PROHIBITED FROM REQUIRING DENTAL PROVIDERS TO PARTICIPATE IN ANY OTHER PUBLIC OR PRIVATE PROGRAM OR TO

1 ACCEPT ANY OTHER INSURANCE PRODUCTS AS A CONDITION OF
2 PARTICIPATING AS A DENTAL PROVIDER.

3 (c) (I) THE STATE DEPARTMENT SHALL RETAIN POLICY-MAKING
4 AUTHORITY, INCLUDING BUT NOT LIMITED TO POLICIES CONCERNING
5 COVERED BENEFITS AND RATE SETTING, AND SHALL MONITOR COMPLIANCE
6 WITH THE CONTRACT AND THE PERFORMANCE OF THE CONTRACTING
7 ENTITY.

8 (II) THE CONTRACTING ENTITY SHALL COMPLY WITH FEDERAL
9 REPORTING REQUIREMENTS AND SHALL PROVIDE THE STATE DEPARTMENT
10 WITH DATA AND INFORMATION NECESSARY FOR THE STATE DEPARTMENT
11 TO MONITOR COMPLIANCE WITH THE CONTRACT AND EVALUATE THE
12 PERFORMANCE OF THE CONTRACTING ENTITY.

13 (3) NOTWITHSTANDING THE PROVISIONS OF PARAGRAPH (a) OF
14 SUBSECTION (2) OF THIS SECTION, THE STATE DEPARTMENT SHALL NOT BE
15 REQUIRED TO ENTER INTO A CONTRACT WITH AN ENTITY FOR THE
16 ADMINISTRATION OF DENTAL SERVICES PURSUANT TO SECTION 25.5-5-102
17 (1) (d) AND (1) (g), IF THE STATE DEPARTMENT DOES NOT RECEIVE A
18 PROPOSAL MEETING THE STATE DEPARTMENT'S CONTRACTING
19 REQUIREMENTS OR TERMS, OR IF THE STATE DEPARTMENT DETERMINES
20 THAT ENTERING INTO A CONTRACT FOR THESE SERVICES IS NOT
21 COST-EFFECTIVE OR EFFICIENT FOR THE STATE OR DOES NOT IMPROVE THE
22 OVERALL QUALITY OF SERVICES PROVIDED TO CLIENTS.

23 **SECTION 2. Act subject to petition - effective date.** This act
24 shall take effect at 12:01 a.m. on the day following the expiration of the
25 ninety-day period after final adjournment of the general assembly (August
26 11, 2010, if adjournment sine die is on May 12, 2010); except that, if a
27 referendum petition is filed pursuant to section 1 (3) of article V of the

1 state constitution against this act or an item, section, or part of this act
2 within such period, then the act, item, section, or part shall not take effect
3 unless approved by the people at the general election to be held in
4 November 2010 and shall take effect on the date of the official
5 declaration of the vote thereon by the governor.

Second Regular Session
Sixty-seventh General Assembly
STATE OF COLORADO

BILL H

LLS NO. 10-0190.01 Brita Darling

HOUSE BILL

HOUSE SPONSORSHIP

Frangas, Apuan, Massey

SENATE SPONSORSHIP

Boyd, Foster, Schwartz

House Committees

Senate Committees

A BILL FOR AN ACT

101 **CONCERNING BEHAVIORAL HEALTH CRISIS RESPONSE SERVICES.**

Bill Summary

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

Health Care Task Force. This bill requires the department of human services (department) to enter into a contract with a nonprofit entity for the provision of initial triage services through a coordinated and integrated crisis response system (system services) for persons experiencing mental health or substance abuse crisis. The system services that are contracted for may include, but need not be limited to, services for a telephone hotline operating 24 hours per day and 7 days per week, services provided through an integrated information technology system, and services provided by community-based crisis centers that provide

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Capital letters indicate new material to be added to existing statute.

Dashes through the words indicate deletions from existing statute.

short-term mental health services to persons in crisis. The department shall be responsible for specifying goals to be achieved by contracting for these system services and shall include specific performance goals and time frames for the provision of the system services.

This bill requires the department to maintain policy-making authority over services provided pursuant to the contract, monitor contract compliance, and evaluate the performance of the contracting entity. The contracting entity shall comply with federal regulations and reporting requirements. The contracting entity shall provide the department with information concerning persons receiving services in accordance with federal and state confidentiality laws and the data and information necessary for the department to monitor and evaluate the contracting entity.

The department shall not be required to contract for the system if the system is not cost-effective for the state, if the system services are not appropriate to address the needs of persons in crisis, or if the system services may be provided in a different manner.

The bill requires the department to report annually to the health and human services committees of the general assembly concerning the services provided through the contract.

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

2 **SECTION 1.** Part 2 of article 1 of title 27, Colorado Revised
3 Statutes, is amended BY THE ADDITION OF A NEW SECTION to
4 read:

5 **27-1-210. Mental health crisis response system - legislative**
6 **declaration - contract.** (1) (a) THE GENERAL ASSEMBLY HEREBY FINDS
7 AND DECLARES THAT:

8 (I) THERE ARE PEOPLE IN COLORADO COMMUNITIES WHO ARE
9 EXPERIENCING MENTAL HEALTH OR SUBSTANCE ABUSE CRISIS AND NEED
10 PROFESSIONAL CRISIS CARE OR URGENT PSYCHIATRIC CARE FROM SKILLED
11 MENTAL HEALTH CLINICIANS AND MEDICAL PROFESSIONALS WHO EXCEL AT
12 PROVIDING COMPASSIONATE CRISIS INTERVENTION AND STABILIZATION;

13 (II) MENTAL HEALTH OR SUBSTANCE ABUSE CRISIS CAN HAPPEN
14 ANY HOUR OF THE DAY AND ANY DAY OF THE WEEK;

1 (III) PERSONS IN CRISIS FREQUENTLY COME IN CONTACT WITH
2 COMMUNITY FIRST RESPONDERS WHO ARE OFTEN UNABLE TO PROVIDE
3 NECESSARY MENTAL HEALTH INTERVENTION OR WHO MUST TRANSPORT
4 THESE PERSONS IN CRISIS TO EMERGENCY ROOMS FOR SERVICES, OR, IN
5 CASES WHERE THE LAW IS BROKEN, TO JAIL;

6 (IV) COLORADO RANKS FIFTIETH IN THE NATION IN THE NUMBER
7 OF INPATIENT PSYCHIATRIC BEDS;

8 (V) FEWER THAN ONE-HALF OF THE PERSONS EXPERIENCING CRISIS
9 WHO END UP IN AN EMERGENCY ROOM ARE ADMITTED FOR INPATIENT
10 HOSPITALIZATION, MEANING THAT THOUSANDS OF PEOPLE EACH YEAR
11 RETURN TO COMMUNITY STREETS WITH LITTLE, IF ANY, MENTAL HEALTH
12 OR SUBSTANCE ABUSE CRISIS INTERVENTION OR TREATMENT; AND

13 (VI) SIGNIFICANT TIME AND RESOURCES ARE REQUIRED OF
14 COMMUNITY FIRST RESPONDERS IN ADDRESSING PERSONS IN MENTAL
15 HEALTH OR SUBSTANCE ABUSE CRISIS AND THAT IN MANY CASES THIS
16 COMMUNITY RESPONSE IS NEITHER TIMELY NOR SAFE FOR THE PERSON IN
17 CRISIS NOR COST-EFFICIENT FOR THE STATE.

18 (b) THE GENERAL ASSEMBLY THEREFORE FINDS THAT:

19 (I) A COORDINATED CRISIS RESPONSE SYSTEM PROVIDES FOR
20 EARLY INTERVENTION AND EFFECTIVE TREATMENT OF PERSONS IN MENTAL
21 HEALTH OR SUBSTANCE ABUSE CRISIS;

22 (II) A COORDINATED CRISIS RESPONSE SYSTEM SHOULD INVOLVE
23 FIRST RESPONDERS AND INCLUDE INFORMATION TECHNOLOGY SYSTEMS TO
24 INTEGRATE AVAILABLE CRISIS RESPONSES;

25 (III) A COORDINATED CRISIS RESPONSE SYSTEM SHOULD BE
26 AVAILABLE IN ALL COMMUNITIES STATEWIDE, TWENTY-FOUR HOURS PER
27 DAY AND SEVEN DAYS PER WEEK; AND

1 (IV) A COORDINATED CRISIS RESPONSE SYSTEM MAY INCLUDE
2 COMMUNITY-BASED CRISIS CENTERS WHERE PERSONS IN MENTAL HEALTH
3 OR SUBSTANCE ABUSE CRISIS MAY BE STABILIZED AND RECEIVE
4 SHORT-TERM TREATMENT.

5 (2) (a) THE DEPARTMENT OF HUMAN SERVICES, REFERRED TO IN
6 THIS SECTION AS THE "DEPARTMENT", SHALL CONTRACT WITH A
7 NONPROFIT ENTITY TO PROVIDE SERVICES FOR PERSONS SUFFERING FROM
8 MENTAL HEALTH OR SUBSTANCE ABUSE CRISIS THROUGH A COORDINATED
9 AND INTEGRATED CRISIS RESPONSE SYSTEM. THE DEPARTMENT SHALL
10 DETERMINE THE SPECIFIC CONTRACTED SERVICES AND, TO THE EXTENT
11 PRACTICABLE, SHALL CONTRACT FOR THE PROVISION OF SERVICES
12 STATEWIDE. THE CONTRACTED CRISIS RESPONSE SYSTEM SERVICES MAY
13 INCLUDE, BUT NEED NOT BE LIMITED TO:

14 (I) SERVICES PROVIDED THROUGH A CRISIS TELEPHONE HOTLINE
15 STAFFED BY SKILLED MENTAL HEALTH PROFESSIONALS OR OTHER
16 QUALIFIED PROFESSIONALS PROVIDING CALLER RESPONSE TWENTY-FOUR
17 HOURS PER DAY AND SEVEN DAYS PER WEEK;

18 (II) SERVICES PROVIDED THROUGH AN INTEGRATED INFORMATION
19 TECHNOLOGY SYSTEM THAT COORDINATES CRISIS RESPONSE, PATIENT
20 RECORDS, PSYCHIATRIC SERVICES AVAILABILITY, AND TREATMENT
21 OPTIONS; AND

22 (III) SERVICES PROVIDED THROUGH COMMUNITY-BASED CRISIS
23 CENTERS FOR PERSONS NEEDING CRISIS COUNSELING AND STABILIZATION
24 OR SHORT-TERM TREATMENT FOR PSYCHIATRIC OR OTHER CO-OCCURRING
25 DISORDERS.

26 (b) THE DEPARTMENT SHALL SPECIFY THE GOALS TO BE ACHIEVED
27 THROUGH THE PROVISION OF CRISIS RESPONSE SERVICES AND SHALL

1 ENSURE THAT THE CONTRACT PURSUANT TO PARAGRAPH (a) OF THIS
2 SUBSECTION (2) CONTAINS SPECIFIC PERFORMANCE GOALS AND TIME
3 FRAMES FOR THE CONTRACTING ENTITY FOR THE PROVISION OF CRISIS
4 RESPONSE SERVICES.

5 (3) THE DEPARTMENT SHALL MAINTAIN POLICY-MAKING
6 AUTHORITY OVER SERVICES PROVIDED PURSUANT TO THE CONTRACT,
7 MONITOR COMPLIANCE WITH THE CONTRACT, AND EVALUATE THE
8 PERFORMANCE OF THE CONTRACTING ENTITY.

9 (4) THE CONTRACTING ENTITY SHALL COMPLY WITH FEDERAL
10 REGULATIONS AND REPORTING REQUIREMENTS AND SHALL PROVIDE THE
11 DEPARTMENT WITH DATA AND INFORMATION CONCERNING PERSONS
12 SERVED THROUGH THE COORDINATED AND INTEGRATED CRISIS RESPONSE
13 SYSTEM IN ACCORDANCE WITH FEDERAL AND STATE CONFIDENTIALITY
14 LAWS AS WELL AS ANY DATA AND INFORMATION NECESSARY FOR THE
15 DEPARTMENT TO MONITOR COMPLIANCE WITH THE CONTRACT AND TO
16 EVALUATE THE PERFORMANCE OF THE CONTRACTING ENTITY.

17 (5) NOTWITHSTANDING THE PROVISIONS OF SUBSECTION (2) OF
18 THIS SECTION, THE DEPARTMENT SHALL NOT BE REQUIRED TO ENTER INTO
19 A CONTRACT FOR THE PROVISION OF CRISIS RESPONSE SERVICES THROUGH
20 A COORDINATED AND INTEGRATED CRISIS RESPONSE SYSTEM IF THE
21 DEPARTMENT DETERMINES THAT ENTERING INTO SUCH A CONTRACT IS NOT
22 COST-EFFECTIVE FOR THE STATE, THAT THE SERVICES PROVIDED THROUGH
23 THE SYSTEM ARE NOT THE APPROPRIATE SERVICES TO ADDRESS THE NEEDS
24 OF PERSONS EXPERIENCING MENTAL HEALTH OR SUBSTANCE ABUSE CRISIS,
25 OR THAT THE SERVICES MAY BE PROVIDED IN A DIFFERENT MANNER.

26 (6) ON OR BEFORE JANUARY 30 OF THE YEAR FOLLOWING THE
27 EXECUTION OF THE CONTRACT, AND ON OR BEFORE EACH JANUARY 30

1 THEREAFTER, THE DEPARTMENT SHALL REPORT TO THE HEALTH AND
2 HUMAN SERVICES COMMITTEES OF THE SENATE AND THE HOUSE OF
3 REPRESENTATIVES, OR ANY SUCCESSOR COMMITTEES, CONCERNING THE
4 STATEWIDE, COORDINATED CRISIS RESPONSE SYSTEM PROVIDED PURSUANT
5 TO THE CONTRACT, THE PERSONS SERVED, AND THE OVERALL
6 EFFECTIVENESS OF THE CONTRACT IN MEETING THE DEPARTMENT'S GOALS
7 AND PERFORMANCE OBJECTIVES WITH RESPECT TO MENTAL HEALTH AND
8 SUBSTANCE ABUSE CRISIS SERVICES.

9 **SECTION 2. Safety clause.** The general assembly hereby finds,
10 determines, and declares that this act is necessary for the immediate
11 preservation of the public peace, health, and safety.