Second Regular Session
Seventieth General Assembly
STATE OF COLORADO

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

LLS NO. 16-0842.01 Brita Darling x2241 **SENATE BILL 16-120**

SENATE SPONSORSHIP

Roberts,

HOUSE SPONSORSHIP

Coram,

Senate Committees
Health & Human Services
Appropriations

House Committees

A BILL FOR AN ACT

CONCERNING PROVIDING AN EXPLANATION OF BENEFITS TO MEDICAID RECIPIENTS FOR PURPOSES OF DISCOVERING POTENTIAL MEDICAID FRAUD, AND, IN CONNECTION THEREWITH, MAKING AN APPROPRIATION.

Bill Summary

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

The bill requires the department of health care policy and financing (department), by a certain date, to develop and implement an explanation of benefits for medicaid recipients. The purpose of the

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.

SENATE
Amended 2nd Reading
April 25, 2016

explanation of benefits is to inform a medicaid client of a claim for reimbursement made for services provided to the client or on his or her behalf, so that the client may discover and report administrative or provider errors or fraudulent claims for reimbursement. The bill specifies certain information that must be included in the explanation of benefits. Specifically, the explanation of benefits must include information regarding at least one method for a medicaid client to report errors in the explanation of benefits.

The department shall work with medicaid clients and medicaid advocates to develop an explanation of benefits and educational materials that are understandable to medicaid clients.

The explanation of benefits must be sent to clients not less than bimonthly, and the department shall determine the most cost-effective means for producing and distributing the explanation of benefits, which means may include e-mail or distribution with existing communications to clients.

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

SECTION 1. In Colorado Revised Statutes, **add** 25.5-4-300.9 as follows:

25.5-4-300.9. Explanation of benefits - medicaid recipients - legislative declaration. (1) (a) THE GENERAL ASSEMBLY FINDS AND DECLARES THAT:

(I) COLORADO'S MEDICAID PROGRAM PROVIDES CRITICAL MEDICAL SERVICES TO THE STATE'S POOREST AND MOST VULNERABLE RESIDENTS;

(II) FUNDING FOR THESE SERVICES IS PROVIDED THROUGH A FINANCIAL PARTNERSHIP BETWEEN COLORADO AND THE FEDERAL GOVERNMENT;

(III) FOR THE 2015-16 STATE BUDGET YEAR, THE GENERAL ASSEMBLY APPROPRIATED $8,891,000,000 FOR COLORADO'S MEDICAID PROGRAM, OF WHICH $2,508,000,000 IS FROM THE GENERAL FUND AND $677,000,000 IS FROM THE HOSPITAL PROVIDER FEE, WITH THE REMAINDER FROM FEDERAL MONEY;

(IV) IT IS IN THE BEST INTEREST OF COLORADO TO DO EVERYTHING POSSIBLE TO MINIMIZE ERROR, INEFFICIENCY, AND FRAUD IN PROVIDING MEDICAID SERVICES TO ENSURE THE LONG-TERM VIABILITY OF THIS SAFETY NET PROGRAM;

(V) IN THE PRIVATE SECTOR, AS WELL AS THE MEDICARE PROGRAM, INSURERS ROUTINELY PROVIDE AN EXPLANATION OF BENEFITS TO THEIR CLIENTS, LISTING CLAIMS SUBMITTED BY PROVIDERS FOR SERVICES RENDERED TO THE CLIENT EVEN WHEN THE INSURER IS NOT SEEKING A CO-PAYMENT FOR THE SERVICE AND THE PROVIDER IS NOT CLAIMING AN AMOUNT DUE FROM THE CLIENT;

(VI) WHILE CREATING AN EXPLANATION OF BENEFITS IS NOT WITHOUT COST TO THE HEALTH CARE SYSTEM, ONLY THE CLIENT RECEIVING MEDICAL SERVICES OR HIS OR HER AUTHORIZED REPRESENTATIVE IS IN THE POSITION TO VERIFY WHETHER THE CLAIMED MEDICAL SERVICES WERE ACTUALLY PROVIDED AND FOR WHOM THEY WERE PROVIDED, WHICH IS A NECESSARY FIRST STEP IN CONTAINING HEALTH CARE COSTS;

(VII) WHILE MEDICAID CLIENTS MAY NOT APPEAR TO BE AFFECTED FINANCIALLY BY BILLING ERRORS OR FRAUDULENT CLAIMS, MEDICAID CLIENTS WHO RELY ON THESE SERVICES FOR SURVIVAL AND INDEPENDENCE ARE MOST SEVERELY AFFECTED BY THE INAPPROPRIATE USE OF SCARCE RESOURCES; AND

(VIII) FURTHER, MEDICAID CLIENTS AND MEDICAID ADVOCATES FOR LOW-INCOME AND VULNERABLE COLORADANS WANT THE OPPORTUNITY TO PARTNER WITH THE STATE DEPARTMENT AND PROVIDERS TO ENSURE A WELL-RUN AND FRAUD-FREE MEDICAID PROGRAM IN COLORADO.

(b) THEREFORE, THE GENERAL ASSEMBLY DECLARES THAT CREATING AN EXPLANATION OF BENEFITS FOR RECIPIENTS OF MEDICAID-FUNDED SERVICES IS A NECESSARY STEP IN MANAGING THE STATE'S MEDICAID PROGRAM AND IN SAFEGUARDING THE SIGNIFICANT PUBLIC INVESTMENT, BOTH STATE AND FEDERAL, IN MEETING THE HEALTH CARE NEEDS OF LOW-INCOME AND VULNERABLE COLORADANS.

(2) BY OR BEFORE JULY 1, 2017, THE STATE DEPARTMENT SHALL DEVELOP AND IMPLEMENT AN EXPLANATION OF BENEFITS FOR RECIPIENTS OF MEDICAL SERVICES PURSUANT TO ARTICLES 4 TO 6 OF THIS TITLE. THE PURPOSE OF THE EXPLANATION OF BENEFITS IS TO INFORM A MEDICAID CLIENT OF A CLAIM FOR REIMBURSEMENT MADE FOR SERVICES PROVIDED TO THE CLIENT OR ON HIS OR HER BEHALF, SO THAT THE CLIENT MAY DISCOVER AND REPORT ADMINISTRATIVE OR PROVIDER ERRORS OR FRAUDULENT CLAIMS FOR REIMBURSEMENT.

(3) THE EXPLANATION OF BENEFITS IS REQUIRED FOR ALL ACUTE AND LONG-TERM CARE SERVICES FOR WHICH A PROVIDER IS SEEKING REIMBURSEMENT UNDER A FEE-FOR-SERVICE MODEL.

(4) THE EXPLANATION OF BENEFITS MUST INCLUDE, AT A MINIMUM:

(a) THE NAME OF THE MEDICAID CLIENT RECEIVING THE SERVICE;

(b) THE NAME OF THE SERVICE PROVIDER;

(c) A DESCRIPTION OF THE SERVICE PROVIDED;

(d) THE BILLING CODE FOR THE SERVICE;

(e) THE DATE OF SERVICE, OR RANGE OF DATES FOR SERVICES, IF MULTIPLE SERVICES ARE PROVIDED IN A SET PERIOD OF TIME, SUCH AS PERSONAL CARE SERVICES;

(f) A CLEAR STATEMENT TO THE MEDICAID CLIENT THAT THE EXPLANATION OF BENEFITS IS NOT A BILL, BUT IS ONLY PROVIDED FOR THE

CLIENT'S INFORMATION AND TO MAKE SURE THAT A PROVIDER IS BEING REIMBURSED ONLY FOR SERVICES ACTUALLY PROVIDED;

(g) INFORMATION REGARDING AT LEAST ONE VERBAL AND ONE WRITTEN METHOD FOR THE MEDICAID CLIENT TO REPORT ERRORS IN THE EXPLANATION OF BENEFITS THAT ARE RELEVANT TO PROVIDER REIMBURSEMENT; AND

(h) ANY OTHER INFORMATION THAT THE STATE DEPARTMENT DETERMINES IS USEFUL TO THE MEDICAID CLIENT OR FOR PURPOSES OF DISCOVERING ADMINISTRATIVE OR PROVIDER ERROR OR FRAUD.

(5) THE STATE DEPARTMENT SHALL DEVELOP THE FORM AND CONTENT OF THE EXPLANATION OF BENEFITS IN CONJUNCTION WITH MEDICAID CLIENTS AND MEDICAID ADVOCATES TO ENSURE THAT MEDICAID CLIENTS UNDERSTAND THE INFORMATION PROVIDED AND THE PURPOSE OF THE EXPLANATION OF BENEFITS. THE STATE DEPARTMENT SHALL ALSO WORK WITH MEDICAID CLIENTS AND MEDICAID ADVOCATES TO DEVELOP EDUCATIONAL MATERIALS FOR THE STATE DEPARTMENT'S WEBSITE AND FOR DISTRIBUTION BY ADVOCACY AND NONPROFIT ORGANIZATIONS THAT EXPLAIN THE PROCESS FOR REPORTING ERRORS AND ENCOURAGE CLIENTS TO TAKE RESPONSIBILITY FOR REPORTING ERRORS.

(6) THE STATE DEPARTMENT SHALL PROVIDE THE EXPLANATION OF BENEFITS TO A MEDICAID CLIENT NOT LESS FREQUENTLY THAN ONCE EVERY TWO MONTHS, IF SERVICES HAVE BEEN PROVIDED TO OR ON BEHALF OF THE CLIENT DURING THAT TIME PERIOD. THE STATE DEPARTMENT SHALL DETERMINE THE MOST COST-EFFECTIVE MEANS FOR PRODUCING AND DISTRIBUTING THE EXPLANATION OF BENEFITS TO MEDICAID CLIENTS, WHICH MAY INCLUDE E-MAIL OR WEB-BASED DISTRIBUTION, WITH MAILED COPIES BY REQUEST ONLY. FURTHER, THE STATE DEPARTMENT MAY

INCLUDE THE EXPLANATION OF BENEFITS WITH AN EXISTING MAILING OR EXISTING ELECTRONIC OR WEB-BASED COMMUNICATION TO MEDICAID CLIENTS.

(7) NOTHING IN THIS SECTION REQUIRES THE STATE DEPARTMENT TO PRODUCE AN EXPLANATION OF BENEFITS FORM IF THE INFORMATION REQUIRED TO BE INCLUDED IN THE EXPLANATION OF BENEFITS PURSUANT TO SUBSECTION (4) OF THIS SECTION IS ALREADY INCLUDED IN ANOTHER FORMAT THAT IS UNDERSTANDABLE TO THE MEDICAID CLIENT.

SECTION 2. Appropriation. (1) For the 2016-17 state fiscal year, $38,800 is appropriated to the department of health care policy and financing for use by the executive director's office. This appropriation consists of $35,350 from the general fund and $3,450 from the hospital provider fee cash fund created in section 25.5-4-402.3 (4) (a), C.R.S. To implement this act, the office may use this appropriation as follows:

(a) $25,000 general fund for general professional services and special projects; and

(b) $13,800, which consists of $10,350 from the general fund that is subject to the "(M)" notation as defined in the annual general appropriation act for the same fiscal year and $3,450 from the hospital provider fee cash fund, for Medicaid management information system maintenance and projects.

(2) For the 2016-17 state fiscal year, the general assembly anticipates that the department of health care policy and financing will receive $149,200 in federal funds to implement this act. The appropriation in subsection (1) of this section is based on the assumption that the department will receive this amount of federal funds to be used as follows:

(a) $25,000 for general professional services and special projects; and

(b) $124,200 for Medicaid management information system maintenance and projects.

SECTION 3. Act subject to petition - effective date. This act takes effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly (August 10, 2016, if adjournment sine die is on May 11, 2016); except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part will not take effect unless approved by the people at the general election to be held in November 2016 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.