DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

Emergency Regulation 20-E-08

CONCERNING CARRIER CARE MANAGEMENT PROTOCOLS FOR THE COLORADO REINSURANCE PROGRAM

Section 1 Authority

This emergency regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109(1), 10-16-109, and 10-16-1105(5), C.R.S.

Section 2 Scope and Purpose

The purpose of this emergency regulation is to establish carrier submission requirements for the Reinsurance Program Care Management Protocols, pursuant to § 10-16-1105(5), C.R.S. Care Management Protocols are intended to promote more cost-effective health care and to be fair to federal taxpayers by restraining growth in federal health care spending commitments. Eligible Carriers are required to submit Care Management Protocols to confirm their strategies for managing claims within the Colorado Reinsurance Program Payment Parameters.

The Division of Insurance finds, pursuant to § 24-4-103(6)(a), C.R.S., that immediate adoption of this regulation is imperatively necessary for the preservation of public health, safety, or welfare to ensure that the Colorado Reinsurance Program is administered in such a way as to ensure Colorado consumers have access to affordable health insurance coverage and to ensure Colorado carriers comply with the requirements of §§ 10-16-1105(5), C.R.S., which is imperative to preserve the health of the citizens of Colorado. Therefore, compliance with the requirements of § 24-4-103, C.R.S., would be contrary to the public interest.

Section 3 Applicability

This emergency regulation applies to all eligible carriers that participate in the Colorado Reinsurance Program pursuant to Title 10, article 16, part 11.

Section 4 Definitions

A. “Attachment Point” shall have the same meaning as found at § 10-16-1103(1), C.R.S.

B. “Benefit Year” shall have the same meaning as found at § 10-16-1103(2), C.R.S.

C. “Care Protocols” means the strategy an Eligible Carrier implements to manage claims within the Reinsurance Payment Parameters and promote more cost-effective health care, pursuant to § 10-16-1105(5), C.R.S.

D. “Eligible Carrier” shall have the same meaning as found at § 10-16-1103(5), C.R.S.

E. “Health Care Provider” means a hospital, physician group, or other medical provider entity licensed or certified by the Department of Public Health and environment pursuant to § 25-1.5-103.

F. “Payment Parameters” shall have the same meaning as found at § 10-16-1103(9), C.R.S.

G. “Reinsurance Program” shall have the same meaning as found at § 10-16-1103(12), C.R.S.

Section 5 Care Management Protocol Requirements

A. Eligible Carriers must develop and implement Care Management Protocols that promote cost-effective care and manage claims costs for enrollees whose claims are expected to exceed the Reinsurance Program Attachment Point. The Attachment Point is $30,000 in total annual claims costs for an individual enrollee for program year 2020. The Attachment Point for program year 2021 was announced by the Division of Insurance (Division) on March 16, 2020.

B. Beginning in 2020, Eligible Carriers shall file the Reinsurance Care Management Protocol Assessment (Appendix A) for the applicable benefit year with its annual rate filing, submitted to the Division per the requirements of § 10-16-107, C.R.S. Care Management Protocols describe Eligible Carriers’ strategies for managing high-cost claims and providing effective care management for members whose claims costs are expected to exceed the Reinsurance Program Attachment Point.

1. Eligible Carriers must use the Reinsurance Care Management Protocol Assessment form (Appendix A) to submit information to the Division to fulfill this requirement.

2. Eligible Carriers must identify enrollees whose claims are expected to fall within the Payment Parameters.

    a. Carriers must identify reinsurance-eligible individuals prospectively, when possible, based on claims history.

    b. In cases where prospective identification of reinsurance-eligible individuals is not possible (e.g. new enrollee with no claims history, or unexpected claims costs due to emergency care), carriers must have care management strategies in place with contracted providers to implement as needed for enrollees whose claims become reinsurance-eligible.

3. Eligible Carriers must implement strategies with contracted providers to manage care costs and utilization for enrollees whose claims are expected to fall within the Payment Parameters.

    a. Carriers must describe the care management services and activities they require contracted providers to perform for the impacted enrollee population.

    b. Carriers must describe how they track care management services and activities performed by contracted providers.

4. Eligible Carriers must describe any payments made to contracted providers for the provision of care management services and activities.

5. Eligible Carriers must estimate the annual savings to the Colorado Reinsurance Program they expect to generate through their Care Management Protocols.

6. Eligible Carriers must include in their submission of the Reinsurance Care Management Protocol Assessment any contracts (e.g. participation agreements, provider agreements, etc.), actuarial analysis or data, and other documentation that support the Eligible Carriers' responses to the Assessment.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This emergency regulation shall be effective May 16, 2020.

Section 9 History

Emergency regulation effective May 16, 2020.

Appendix A: Reinsurance Care Management Protocol Assessment

Eligible Carriers must submit written responses to the following questions:

(Limit: 1500 words*)

1) Provide an overview of the carrier's care management strategy for members whose annual claims costs are expected to exceed the Reinsurance Program Attachment Point.

- Describe how the carrier supports the provision of care management through its provider contracts and how it uses care management to promote cost-effective health care.
- State the carrier's financial and care delivery goals related to care management.
- Describe how the carrier identifies members whose claims are expected to be eligible for reinsurance.

2) State the carrier's requirements for contracted providers regarding patient care management for members whose claims may be eligible for reinsurance.

- Which members receive care management? How, when, and by whom are these members identified? How are members notified regarding care management?
- State the care management activities or services that providers are required to offer. What is the typical frequency and duration of these services?
- Which provider groups are required to perform care management activities, and which practitioners within these groups perform the activities (e.g. physicians, non-physician practitioners, care coordinators, patient navigators, etc.)?
- Approximately how many FTEs does the carrier expect providers to allocate per patient for care management?

3) Describe how the carrier tracks care management services and activities performed by contracted health care providers.

- Does the carrier require contracted providers to report on the care management services and activities they perform? If yes, describe the reporting requirements.
- To what extent does the carrier use claims data to track care management?
- Does the carrier require providers to report particular quality measures (MIPS, NQF, etc.) related to care management or care coordination? If yes, list the measures.
- Describe any data validation or auditing processes the carrier uses to verify care management data from providers.
- Describe any penalties the carrier imposes in cases where providers do not meet care management requirements.

4) Describe any claims-based or non-claims-based payments the carrier provides for care management activities and services.

- Does the carrier provide per-member-per-month or other regularly scheduled payments for member care management? If yes, describe the amount and frequency of the payment, and state the activities and services it covers.

5) Estimate the savings to the Colorado Reinsurance Program the carrier expects its Care Management Protocols to generate.

- Savings should be represented by average annual claims reductions per enrollee for enrollees whose claims are eligible for reinsurance, along with aggregate savings across all eligible enrollees.

6) Attach any contracts (e.g. participation agreements, provider agreements, etc.), actuarial analysis or data, and other documentation supporting the responses above.

*Word limit does not apply to attached contracts or supporting materials.