COLORADO

GENERAL ASSEMBLY

Long-Term Health Care

Legislative Task Force on
Long-Term Health Care

Legislative Council
Research Publication No. 344

December 1989

RECOMMENDATIONS FOR 1990

LEGISLATIVE TASK FORCE ON LONG-TERM HEALTH CARE

Report to the
Colorado General Assembly

Research Publication No. 344
December, 1989

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To Members of the Fifty-Seventh Colorado General Assembly:

Submitted herewith is the final report of the Legislative Task Force on Long-Term Health Care, which was created by House Bill 1046 in the 1988 legislative session. The purpose of the task force was to coordinate the state's long-term health care system into one that is well-organized, managed, and controlled.

At its meeting on November 3, 1989, the the task force acted to recommend the proposed bills which are detailed herein. These bills were submitted to and approved by the Legislative Council at its meeting on November 9, 1989.

Respectfully submitted,

Dottie

Senator Dottie Wham, Chairman
Legislative Task Force on
Long-Term Health Care

TABLE OF CONTENTS

Page

LETTER OF TRANSMITTAL iii

TABLE OF CONTENTS v

LIST OF BILLS vii

TASK FORCE ON LONG-TERM HEALTH CARE

Members of the Committee 1
Summary of Recommendations 3
Task Force Charge 5
Objectives 5
Development of a Study Plan 5
Task Force Activities 9
Long-Term Care Inventory 10
Acknowledgements 10

TASK FORCE RECOMMENDATIONS

Single Entry Point 11
Ombudsman Act 11
Reimbursement Methodology 12
PACE Program 13
Long-Term Care Insurance 13
Personal Care Boarding Homes 14
Hospice Care 14
Case Management System 15
Alzheimer's Disease Resolution 15

BACKGROUND REPORT

Table 1 -- Projected Growth in Colorado's Aging Population 16
Table 2 -- Public Expenditures for Long-Term Health Care 16
Financing of Long-Term Health Care 17
Needs of Special Populations 20
Alzheimer's Disease 22
Quality of Care 24
Continuum of Care 26
Case Management 28

APPENDICES

A -- Selected References 31
B -- Letters of Endorsement 33
C -- Long-Term Care Inventory 43

BILLS 1 THROUGH 8 AND JOINT RESOLUTION 1 61

LIST OF BILLS

		Page
Bill 1	Concerning a Reorganization of Service Delivery for persons in Need of Long-Term Care Through a Single Entry Point System, and, In Connection Therewith, Adopting a Uniform Assessment Instrument	61
Bill 2 -	Concerning the Enactment of a State Long-Term Care Ombudsman Act in Compliance With the Federal "Older Americans Act of 1965", as Amended	67
Bill 3 -	Concerning Payment to Vendors Who Provide Long-Term Care Services Under the "Colorado Medical Assistance Act", and Making an Appropriation in Connection Therewith	73
Bill 4 -	Concerning the Replication of a Comprehensive Long-Term Care Capitation Model Program of All-Inclusive Care for the Elderly	79
Bill 5 -	Concerning Long-Term Care Insurance	83
Bill 6 -	Concerning the Regulation of Personal Care Boarding Homes	91
Bill 7 -	Concerning the Inclusion of Hospice Care as a Service Under the "Colorado Medical Assistance Act", and Making an Appropriation Therefor	95
Bill 8 -	Concerning the Development of a Case Management System for Certain Publicly Assisted Disabled Clients in Need of Long-Term Care, and Making an Appropriation Therefor	97
Joint Resolution 1 -	Concerning Alzheimer's Disease Research Funding	101

TASK FORCE ON LONG-TERM HEALTH CARE

Members of theTask Force

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SUMMARY OF RECOMMENDATIONS

Long-term health care provides the help needed for a person to cope, and sometimes to survive, when physical or mental disabilities impair the capacity to perform the basic activities of everyday life. Long-term health care is usually associated with our elderly and disabled populations, particularly in terms of nursing home care. However, it is a need that can be experienced by any person, at any age, in a variety of situations and can prove to be financially catastrophic. The elderly, chronically mentally ill, developmentally disabled, and nonelderly physically disabled are all populations with pressing long-term health care needs. Demographic data indicates that Colorado's elderly and disabled populations in need of long-term health care will more than double between the years 1980 and 2000. More to the point, the number of those aged 85 and older -- who are most likely to need long-term health care -- will increase significantly. This rapidly growing population of elderly over age 85, in addition to the other populations needing long-term health care, is resulting in an unprecedented demand for long-term health care services.

Currently, Colorado has a fragmented system for the delivery of long-term health care services. Services for long-term health care have evolved in a piecemeal fashion. Individuals and their families often face a confusing maze in attempting to obtain these services. Persons experience difficulty in accessing the system, are unaware of the range of available services, confront differing program eligibility requirements, and wrestle with a burdensome client application and assessment process. In addition, the rural areas of the state often have fewer resources to cope with these long-term health care needs.

Public expenditures for long-term health care in the state are expected to reach or exceed $502 million by the year 2000. Due to the lack of alternative financing mechanisms for long-term health care, the burden of financing this type of care falls on individuals through out-of-pocket expenditures and on the state through the Medicaid program. Most individuals requiring long-term health care have no insurance to cover the rising cost and frequently find themselves impoverished within a short amount of time.

The type of care provided in home and community settings is preferred by individuals and frequently found to be more cost-effective than traditional long-term health care. This preference will lead to a greater demand for community-based long-term health care services, placing additional pressure on the organization, staffing, and financing of such services in the state. Changing demographics and increasing expenditures coupled with the lack of coordination of the long-term health care system pose important policy issues for Colorado.

The task force looked at a variety of long-term health care policy issues including: developing new financing mechanisms, community alternatives to institutional care,

the needs of special populations, ensuring quality of care, providing a continuum of care, and implementing measures to control costs. The task force strongly believes that the following recommendations will help improve the state's long-term health care system.

Single Entry Point. Bill 1 better organizes client entry, assessment, and service delivery for long-term health care by providing for a single entry point and uniform assessment instrument.

Ombudsman Act. Bill 2 brings Colorado's Ombudsman Program into compliance with federal law by establishing the program's structure and duties in statute.

Nursing Home Reimbursement Methodology. Bill 3 contains three provisions relating to reimbursement methodology and long-term health care services. Part 1 allows an increase to vendors under the Colorado Medical Assistance Act to cover newly incurred costs related to the training of nurses aides. The second part revises the methodology for reimbursing nursing home providers from a daily rate based on audited costs for each facility to one which recognizes the varying resources needed for different clients. The third part establishes a quality of care incentive allowance as a means of rewarding long-term health care providers that furnish a high level of care.

Long-Term Care Capitation Model Program. Bill 4 grants the Department of Social Services authority to apply for federal Medicaid waivers needed to implement a replication project of all-inclusive care for the frail elderly.

Long-Term Care Insurance. Bill 5 enacts the Long-Term Care Insurance Act which sets forth standards for policies, details the elements of coverage, and provides for consumer protection.

Personal Care Boarding Homes. Bill 6 authorizes the Department of Health to impose a civil penalty against unlicensed personal care boarding homes and to obtain a criminal history check of personal care boarding home owners, operators, administrators, and staff.

Hospice Care. Bill 7 includes hospice care as a service for Medicaid-eligible persons. The intent of the bill is to substitute lower cost hospice care for hospital or nursing home care.

Case Management System. Bill 8 requires a case management study by the Department of Institutions or Social Services of disabled clients with mental impairments.

Alzheimer's Disease Research Funding. Resolution 1 urges the U.S. Congress to increase federal support for research of Alzheimer's Disease and related disorders.

INTRODUCTION

Task Force Charge

Recognizing a need for the development and support of a well-organized, managed, and controlled long-term health care system in the state in order to meet the need for a comprehensive long-term care system, the General Assembly enacted House Bill 1046 in the 1988 legislative session. This act created the Task Force on Long-Term Health Care which was charged with a broad 18 month study of the complex area of long-term health care policy, delivery, and financing.

Objective

The objective of the task force was to coordinate the state's fragmented long-term health care system into one that is better organized. In conducting its study, the task force identified issues of concern to the entire population in need of long-term health care. Consideration was given to those services designated to provide diagnostic, preventative, therapeutic, rehabilitative, supportive, and maintenance services for individuals with chronic mental or physical conditions in hospitals, nursing homes or other alternative care settings. By adopting this broad perspective of long-term health care, the task force was able to take a more comprehensive view of the state's long-term health care population, fiscal role, and delivery system.

Development of a Study Plan

House Bill 1046 required the appointment of a 24 member task force on long-term health care. In addition to four legislators, members of the task force include those knowledgeable of long-term health care as it pertains to: hospitals, nursing homes, dietetics, government regulations, developmentally disabled, mental health, senior citizens, neurologic conditions, Alzheimer's Disease, and veterans. Membership also includes the state's Long-Term Care Ombudsman, the Chancellor of the University of Colorado Health Sciences Center, and the executive directors of the Departments of Health, Institutions, and Social Services.

In an effort to better address the numerous and complex study charges and effectively utilize the time of the task force, members agreed to establish four subcommittees, in addition to the two statutorily created subcommittees (Alzheimer's Disease and Case Management). The subcommittees were designed to serve as working groups of the task force. The four new subcommittees established were: Financing/Case Mix Reimbursement, Quality of Care, Continuum of Care, and Special Populations. Interested legislators and other individuals were invited to serve on any of the subcommittees. Over 150 persons volunteered to participate.

Task force members suggested that the subcommittees: identify the strengths and weaknesses of the present system; review existing studies; consider the roles of the state, local government, and private sector relating to long-term health care; evaluate ways to improve long-term care access; review recent federal legislation concerning long-term health care that impacts the state; and study the urban and rural systems of long-term health care. Each subcommittee and its charges are listed below.

Subcommittee on Financing/Case Mix Reimbursement System (Chairman: Tom Sangster, Colorado Hospital Association)

- Study innovative funding mechanisms, including but not limited to long-term care insurance, social health maintenance organizations, reverse home equity programs, and individual medical accounts.
- Consider tax incentives and sources of private and public funds.
- Review rate and reimbursement methodology for community-based and institutional services.
- Evaluate the relationship of the rates for private paying nursing home residents compared to those rates being charged residents eligible for assistance under the "Colorado Medical Assistance Act."
- Review reimbursement of dietetic services under insurance laws.
- Study reimbursement for those persons under the age of 65.
- Address spousal impoverishment.
- Address the "Utah Gap," which refers to individuals with income above welfare eligibility, but still in need of assistance.

Subcommittee on Special Populations (Chairman: Arlene Linton, Colorado Health Care Association)

- Study the needs of special populations requiring long-term care.
- Evaluate the needs of the developmentally disabled.
- Study the diagnosis and treatment of certain diseases and conditions, including AIDS.
- Review disabled adult protection including guardianship programs.
- Consider the special needs of the veteran population.

- Evaluate the special needs of the elderly blind.
- Study the special needs of the chronically mentally ill population to determine what services may be lacking.

Subcommittee on Quality of Care (Chairman: Virginia Fraser, Long-Term Care Ombudsman)

- Study the methods to ensure adequate standards for board and care homes and provide quality of care for patients.
- Evaluate nutrition and education training programs.
- Consider the need for the development of nutrition services to prevent chronic disease and improve the general health of citizens.
- Review the impact of shortages of physical therapists, nurses, and other health care providers on the long-term care system. Study what impact a continuum of care has on the quality of long-term health care.

Subcommittee on Continuum of Long-Term Health Care, Including Nursing Homes, Home Health Care, and Other Alternative Care (Chairman: Representative Norma Anderson)

- Integrate programs and services into a continuum of care.
- Consider support of family caregivers.
- Evaluate respite care services.
- Discuss education and training of the public and of caregivers.
- Review nursing home regulations.
- Study hospice care services.

Subcommittee on Alzheimer's Disease (Chairman: Senator Dennis Gallagher)

- Study all aspects of Alzheimer's Disease from diagnosis through treatment, cure, and research, and the impacts of the disease on the health care system, family systems, social support system, and financing system.

- Consider the current interaction of relevant policies and programs and make recommendations for improvements and methods to improve coordination and reduce duplication of effort.

- Review available data and recommend other types of data that would be useful to collect.

- Discuss major issues, in coordination with the study of these topics by the task force, including: reimbursement for those persons under sixty-five; family support; nursing home regulations; access to care; diagnosis and treatment; public and private financing; education and training; public information; Alzheimer's specific programs; and continuum of care models with case management.

- Develop specific programs for Alzheimer's Disease.

Subcommittee on Case Management (Chairman: Senator Dottie Wham)

- Study the delivery, administrative structure, and financing implications of case management services for developmentally disabled persons, disabled chronically mentally ill, physically disabled, including the frail elderly, and emotionally or behaviorally disturbed persons.

- Consider the feasibility and cost-effectiveness of establishing an independent and external case management system which is separated from any service provider for all developmentally disabled persons, disabled chronically mentally ill, physically disabled, including the frail elderly, and emotionally or behaviorally disturbed persons which would serve clients of the Departments of Education, Health, Institutions, Corrections, and Social Services.

- Review the citywide case management demonstration project operated in the City and County of Denver.

- Review the delivery of case management services in urban, suburban, and rural areas of the state.

- Discuss similar case management programs in other states which serve developmentally disabled persons, disabled chronically mentally ill, physically disabled, including the frail elderly, and emotionally or behaviorally disturbed persons.

- Study the impact of case management on Medicaid funding.

- Review client assessment.

- Evaluate the development of the long-term care access system.

Task Force Activities

The activities of the task force involved more than 70 subcommittee and task force meetings, research, discussion, and the concerted efforts of various concerned parties. Testimony and discussion focused on the need for a comprehensive long-term health care system in Colorado. The Task Force received technical assistance from the National Conference of State Legislatures and the Resource Center on Aging of Brandeis University, and the Departments of Health, Institutions, and Social Services. This technical assistance focused on issues such as the financing of long-term health care, common elements of federal long-term health care policy and its implications for Colorado, and the development of a private market for community based long-term health care.

In 1989, the task force recommended seven bills to comply with the Omnibus Budget Reconciliation Act of 1987, a far reaching nursing home reform law, and the Medicare Catastrophic Coverage Act of 1988. Six of the bills were enacted into law. These laws concern intermediate sanctions for noncompliance of nursing homes to federal standards, a nursing home patient's bill of rights, protection of spouses of Medicaid-funded nursing home residents from impoverishment, providing at-home and community-based care for persons with acquired immune deficiency syndrome, prohibiting reimbursement to spouses for personal care services and and expansion of certain Medicaid benefits to Medicare eligible and disabled individuals.

The task force faced a number of challenges in developing its recommendations. Initially, there were over 20 recommendations for legislation. However, despite the complex and varied charges, the limitation of eight legislative recommendations for statutory committees forced the task force to prioritize its proposals. As a result, not all recommendations were given final approval and some were combined into single proposals. This task was difficult because of the importance of the numerous long-term health care issues.

The task force expressed concern that the General Assembly usually addresses only pieces of the health care field when there is a need to abandon parochial viewpoints and take a more comprehensive long-range view of the entire health care delivery system. A permanent legislative committee is apparently needed to provide oversight of the entire health care field. In addition, Colorado must recognize that rural areas of the state have fewer resources to deal with their long-term health care needs.

The task force makes nine recommendations which address: 1) a single entry point; 2) the Ombudsman Program; 3) reimbursement methodology for long-term health care; 4) a long-term care capitation model program; 5) long-term care insurance; 6) personal care boarding homes; 7) hospice care; 8) a case management system; and 9) Alzheimer's Disease research. While nine of the recommendations are addressed in task force bills and resolution, others are general recommendations

urging action by the General Assembly, the Departments of Health, Institutions, or Social Services, and other organizations (see Appendix B).

Long-Term Care Inventory

One of the task force charges was the development and presentation of a unified long-term care plan and budget including all programs, services, and state expenditures falling under the continuum of care. The Departments of Health, Institutions, and Social Services have compiled an inventory of long-term care services. This long-term care plan has been prepared for fiscal year 1989-90 and will be refined and updated in the future. The plan and budget covers regulation and oversight, direct client services, contract client services, full time equivalents (FTE's) and total appropriations for long-term care in Colorado (see Appendix C).

Acknowledgements

As mentioned, over 150 persons participated in the study, and the members of the task force depended on the expertise and valuable insight of these individuals. In addition, the study could not have been completed without the expert assistance of Bill Hanna, Dr. Dann Milne, Joan Bell, Marilyn Golden, Dr. Mark Litvin, Dr. Gary Toerber, Dr. Deborah Lower, Mildred Simmons, Elaine Sabyan, Melissa Davis, Juanita Tate, Meryl Stern, Bea Holland, Dr. John Capitman, Fran Yehle, and Ellen Ward. Finally, members of the task force are particularly grateful to The Colorado Trust Foundation for providing a grant which enabled members residing in the state's rural areas to attend task force meetings.

TASK FORCE RECOMMENDATIONS

Concerning a Reorganization of Service Delivery For Persons in Need of Long-Term Care Through a Single Entry Point System, and, In Connection Therewith, Adopting a Uniform Assessment Instrument -- Bill 1

Presently, Colorado does not have a single coordinated system for providing long-term care services. Individuals and families needing long-term care services often have difficulty accessing and using the current system. The intent of Bill 1 is to better organize client entry, assessment, and service delivery for long-term health care by providing for a single entry point. A single entry point is an agency in a local community which all elderly and disabled clients must use to obtain needed publicly funded long-term care services. The Department of Social Services will be required to develop and implement a long-term care uniform client assessment instrument, in order to determine appropriate services and levels of care to meet the needs of clients.

An assessment instrument will be administered to all clients to: assure a uniform single assessment of needs, span all long-term health care services, and integrate the collection of services into a continuum of care. The assessment instrument will also determine payment sources for such care and assist private paying clients in selecting long-term care services. In addition, the single entry point will contain the case management mechanisms necessary to control long-term care service delivery for public programs.

The Department of Social Services is required to conduct a comprehensive study by October 1990. This study will focus on the establishment of centralized systems at the local level for: disseminating long-term care information; consolidating long-term care resources; assessing individuals' long-term care needs; and delivering appropriate long-term care under a plan of care which includes case management.

Concerning the Enactment of a State Long-Term Care Ombudsman Act in Compliance With the Federal "Older Americans Act of 1965", as Amended -- Bill 2

Bill 2 will bring the state's Ombudsman Program into compliance with federal law by establishing the program's structure and duties in statute. Colorado has had a long-term care Ombudsman Program since the mid 1970s under the authorization, funding, and requirements of the federal "Older Americans Act." The Ombudsman Program is operated in Colorado by the Legal Center Serving Persons with Disabilities under a contract from the Department of Social Services. However, the federal requirement to assure that these provisions are met is placed on the Department of Social Services as the state agency responsible for the administration of the "Older Americans Act."

The department has been able to meet the federal requirements through regulatory and administrative actions. However, recent amendments to the "Older Americans Act" governing the Ombudsman Program are not able to be met without statutory authorization. Bill 2 establishes a statewide program which consists of a state office, administered by the state's Long-Term Care Ombudsman, and local offices designated by the ombudsman as representatives of the state office. The ombudsman will be responsible for implementing a program designed to assist residents of long-term care facilities in asserting their civil, human, and legal rights. The bill also grants civil and criminal immunity for ombudsmen who act in good faith, and it imposes sanctions against persons who interfere with any ombudsman.

Concerning Payment to Vendors Who Provide Long-Term Care Services Under the "Colorado Medical Assistance Act", and Making an Appropriation in Connection Therewith -- Bill 3

Bill 3 contains three provisions relating to reimbursement methodology and long-term care services. Part one authorizes the Department of Social Services to increase payments to nursing home vendors under the "Colorado Medical Assistance Act." The purpose of this increase is to allow vendors to cover newl incurred costs related to the requirements under the federal "Omnibus Budget Reconciliation Act of 1987" (OBRA). Federal law required that all nurse aides be trained and that a central registry be established. Colorado enacted legislation to comply with this requirement during the 1989 special session. OBRA requires that nursing homes be reimbursed for any additional costs they incur in meeting these requirements. Therefore, Bill 3 includes a provision for the passing through of these additional costs.

The second part of Bill 3 revises the Department of Social Services' methodology for reimbursing nursing home providers. This will provide an alternative method for reimbursement. The reimbursement method is changed from a daily rate based on audited costs for each facility to one which recognizes the varying resources needed for different clients. Thus, a portion of a nursing home's reimbursement rate will be based on the "case mix" of their resident population. A home with a case mix of heavier care clients will receive a higher reimbursement rate than one with lesser care demands.

Bill 3 contains a pilot project implementation of the case mix system, centered around 20 nursing facilities throughout the state, in order to fully study the cost-efficiency of implementing a statewide case mix reimbursement system. The bill also creates an advisory committee to assist the Department of Social Services in designing the project, developing rules and regulations, and evaluating the project.

The third portion of Bill 3 will establish a quality of care incentive allowance to be distributed to approved long-term care facilities which are in compliance with conditions and standards in the annual initial Medicaid recertification survey. This is

a means of rewarding long-term health care providers that furnish high quality care by enhancing patients' rights, involvement, and freedom of choice. An advisory committee will establish criteria, review applications, and award the incentive allowance. The Department of Social Services will verify that the award is used for its intended purpose.

Concerning the Replication of a Comprehensive Long-Term Care Capitation Model Program of All-Inclusive Care for the Elderly -- Bill 4

Denver has been selected as one of ten replication sites in a national replication of the San Francisco ON LOK model of risk-based comprehensive long-term care. The goal of the replication project is to determine whether this financing services model can be successfully adapted to other communities. This project intends to replicate a program of all-inclusive care for the frail elderly, known as the "Program of All-Inclusive Care" (PACE Program), that has proven to be cost effective and has been authorized by the United States Congress.

The program will service a population that meets the Colorado Medicaid eligibility criteria for nursing home placement. The program will receive a capitated amount for each participant enrolled in the program based on a negotiated rate with the Colorado Department of Social Services for Medicaid reimbursement and with the Health Care Financing Administration (HCFA) for Medicare reimbursement. The program will assume full financial responsibility for the medical needs of the individuals electing to participate in the program under this capitated rate by the third year of the project. Bill 4 grants the Department of Social Services the authority to apply for a federal Medicaid waiver to implement the PACE program at the same time the replication project is applying for federal Medicare waivers.

Concerning Long-Term Care Insurance -- Bill 5

Long-term care insurance is a relatively new type of private insurance. Because insurance for long-term care has been limited in the past, people have had to either pay for their own care or become impoverished in the process and qualify for Medicaid. This type of insurance covers skilled, intermediate, and custodial care in state-licensed nursing homes. It also covers home health services provided by state-licensed and/or Medicare certified home health agencies. Most policies available today are called indemnity policies, meaning they pay a set amount, usually a fixed dollar amount per day for nursing home or home health care. No policy, however, provides full coverage for all expenses.

Bill 5 enacts the "Long-Term Care Insurance Act" approved by the National Association of Insurance Commissioners. The bill:

- sets forth standards for long-term care insurance policies, including disclosure to consumers about the benefits and terms of such policies and requirements concerning preexisting conditions, hospitalization, and institutionalization;
- provides that a policy holder has the right to return the policy and obtain a refund of the premium within a certain number of days after delivery of the policy;
- details the elements of coverage in such policies; and
- repeals existing statutes governing long-term care policies.

<u>Concerning the Regulation of Personal Care Boarding Homes -- Bill 6</u>

With the implementation of the "Omnibus Budget Reconciliation Act of 1987" requirements concerning deinstitutionalization of the mentally ill in nursing homes, the chronically mentally ill are likely to live in personal care boarding homes because of the lack of residential alternatives. These boarding homes must be safe facilities, with proper oversight, and residents must be appropriately placed and receive an adequate level of care. The task force concluded that attention to personal care boarding homes must be a high priority and that licensure procedures and agency supervision must be adequately funded.

Bill 6 amends the definition of "personal care boarding home" to clarify that the term includes residential facilities that provide described services directly or indirectly. In addition, the Department of Health is authorized to impose a civil penalty against any unlicensed homes. To assist with the funding of the department's administrative costs, a personal care boarding home cash fund, comprised of licensing fees and civil penalties collected by the department will be created. The department is authorized to obtain a criminal history check of personal care boarding home owners, operators, administrators, and staff.

<u>Concerning the Inclusion of Hospice Care as a Service Under the "Colorado Medical Assistance Act", and Making an Appropriation Therefor -- Bill 7</u>

The intent of Bill 7 is to substitute lower cost hospice care for hospital or nursing home care under the Colorado Medicaid program. Because Colorado's Medicaid program does not offer a hospice benefit, many terminally ill Medicaid patients are hospitalized. Hospice care offers palliative care, pain control, symptom management, and emotional support for the patient and family. This type of care is nationally recognized as a cost effective alternative to traditional medical care for persons who

are terminally ill. States have the option to provide for a hospice benefit under the Medicaid plan. The State Board of Social Services would be required to promulgate rules and regulations concerning the provision of hospice care.

Concerning the Development of a Case Management System For Certain Publicly Assisted Disabled Clients in Need of Long-Term Care, and Making an Appropriation Therefor -- Bill 8

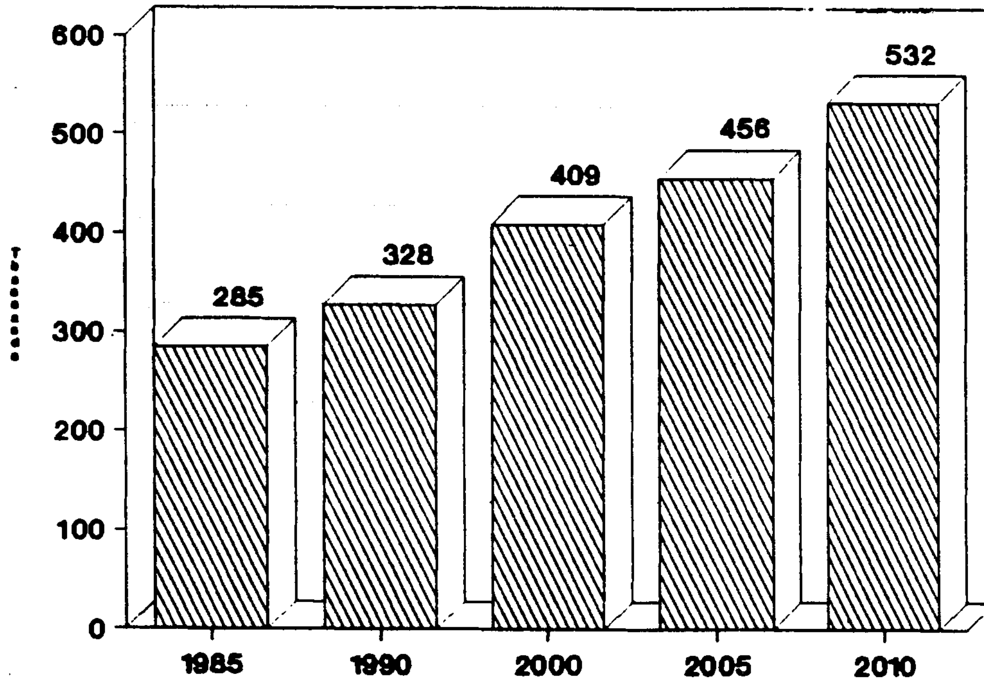
Bill 8 requires a case management study of disabled clients with mental impairments served by the Departments of Institutions and Social Services. The Governor is directed to select an executive department to conduct this study. This study will focus on an urban area of the state and an advisory committee will assist in conducting the study. The department that is selected will also develop and administer a pilot project using an independent case management system for the delivery of services to specified disabled clients. The pilot project will be conducted in a rural area.

Concerning Alzheimer's Disease Research Funding -- Joint Resolution 1

Joint Resolution 1 urges Congress to increase federal support in order to address some of the major issues still surrounding Alzheimer's Disease and related disorders. These issues include: identifying the underlying cause or causes; developing a diagnostic screen that can identify the presence of this disorder prior to the presence of clinical signs; and investigating the application of drugs or therapeutic agents that could aid in the treatment of the disease. The task force concluded that medical research offers the only hope for understanding and eventually eliminating Alzheimer's Disease and related disorders and recommends that the General Assembly adopt this joint resolution to the United States Congress.

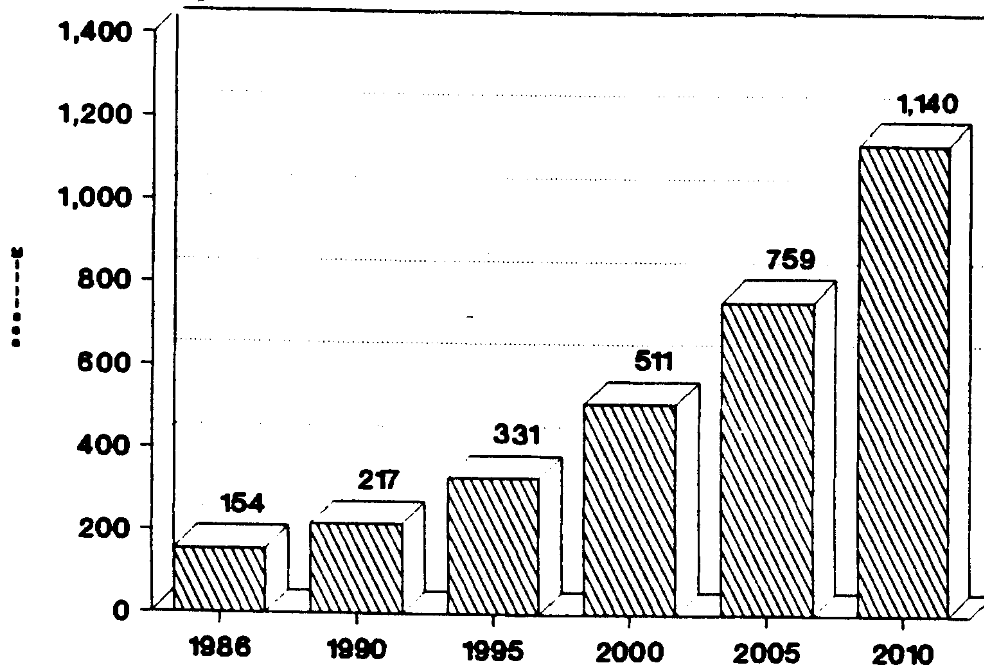
Demographic Trends

Table 1



Public Expenditures

Table 2



FINANCING OF LONG-TERM HEALTH CARE

There is a widely held misconception that the federal Medicare program or most ordinary health insurance covers long-term health care costs. However, more than half of all long-term care costs are paid for out-of-pocket by patients or their families. Medicare pays less than 2 percent, private insurance less than 1 percent, and Medicaid must pick up most of the remainder. The U.S. Department of Health and Human Services estimates that the lifetime risk of entering a nursing home is between 20 and 45 percent. Some individuals choose to rely on Medicaid to cover the expenses of long-term health care, but individuals who rely on Medicaid face the prospect of virtually losing all of their assets in order to qualify for coverage. Others may choose to rely upon personal assets to meet long-term care expenses. But, many individuals who enter nursing homes as private patients quickly exhaust all financial resources. Alternatives to nursing home care are limited and can be costly. Adding to this strain are poor families with children who compete with the disabled elderly for limited Medicaid funding.

The task force explored innovative funding mechanisms designed to help protect individuals against the cost of long-term care and ultimately reduce public expenditures for this type of care. The task force made the following major findings:

Finding #1 -- Provide mechanisms to enable individuals and their families to fund their own long-term care needs, such as long-term care insurance.

Finding #2 -- Encourage the development of alternative long-term care service delivery mechanisms, such as social health maintenance organizations.

Finding #3 -- Provide a more equitable system of reimbursement for nursing homes in order to encourage nursing home efficiency and improve the quality of care, including a patient-based case mix reimbursement system and a quality of care incentive allowance.

Finding #4 -- Promote systems that would precisely explain eligibility for various aging and medical assistance programs, such as a single entry point and the purchase of computer system enhancements.

Finding #5 -- Take advantage of existing techniques to fund long-term care services, such as a program for the medically needy, through the Medicaid program.

Finding #6 -- Recover a portion of the costs of providing medical assistance from the estates of medical assistance recipients.

The Task Force Recommends:

Long-term care insurance. This proposal will help individuals finance long-term care through private insurance. Long-term care policies usually pay for skilled, intermediate or custodial care in a nursing home. Also, policies usually cover home health care services such as skilled or nonskilled nursing care and homemaker and home health aides. Almost all available policies are "indemnity" policies, meaning they pay a set amount for care in a nursing home or for home health care. When an insurance company's risk is limited to a specific amount, they can offer a less expensive and more comprehensive policy. It is hoped that this proposal will encourage more people to buy private insurance and thus limit future state expenditures while sparing individuals the need to impoverish themselves before qualifying for Medicaid. Bill 5 permits the standards for this type of insurance product to be enacted. This bill is based on the National Association of Insurance Commissioners model act, and includes provisions for disclosure to consumers about benefits and terms of the policies and requirements concerning preexisting conditions, hospitalization, and institutionalization.

Social health maintenance organization. This type of organization is an innovative health care delivery system, similar to a health maintenance organization, that provides limited long-term care services as well as acute care. Because they operate on a fixed per patient monthly fee, these organizations have strong incentives to provide care more efficiently. Social health maintenance organizations also provide a single point of access to services and eliminate the arbitrary boundary between acute care hospital and physician services and long-term care services. Denver has been selected to participate in a program that replicates the ON LOK model of risk-based comprehensive long-term care. This program of all inclusive care for the elderly (PACE), has proven to be cost effective and utilizes managed care by capitation. A primary benefit of the PACE program is that it keeps individuals at home by coordinating an extensive array of medical and nonmedical services, including services provided for by Medicare and Medicaid programs. The needs of the program participants are met in an out-patient environment in an Adult Day Health Center. Bill 4 directs the Department of Social Services to evaluate the appropriateness of applying for Medicaid waivers from the federal government in order to participate in the replication project.

Reimbursement methodology. Case mix has the potential for providing a more equitable system of reimbursement for nursing homes and enhancing the quality of care. A case mix reimbursement system assesses each patient's condition and measures actual types of care they will need on a regular basis, as well as the time and level of skill necessary to provide those services. This system uses a measurement of activities of daily living limitations such as eating, toileting, and mobility, and by assessing mental status and behavioral problems. Thus, a portion of a nursing home's reimbursement rate will be based on the "case mix" of their resident population. Bill 3 revises the Department of Social Services' methodology for reimbursing nursing

home providers by utilizing case mix. Financial incentives are recommended to assure nursing home providers have a motivation to achieve high standards of care. Bill 3 also provides a means of rewarding providers that furnish a high level of care by establishing a quality of care incentive allowance. This allowance will be distributed to approved long-term care facilities which are in compliance with conditions and standards in the annual initial Medicaid recertification survey.

Computer expert software system. Bill 1 requires the Department of Social Services to develop and implement a long-term care uniform client assessment instrument in order to determine appropriate services and levels of care which meet the needs of clients. The task force determined that an additional improvement to the long-term care system will involve the use of advanced computer technology to improve the coordination of the eligibility application and determination process. As part of their budget initiative, the Department of Social Services has recommended the purchase of "expert system" software. This software can be used more efficiently to determine various human services program eligibility such as Aid to Dependent Families with Children, food stamps, Medicaid, and can be expanded to the Medicare and Supplemental Security Income programs. All state and federal statutes, and rules and regulations that impact social services programs will be contained in the system. This proposal will more precisely explain eligibility for the various aging and medical assistance programs. The task force urges the General Assembly to favorably act on funding the request for the newly developed "expert system" software package.

Medically needy program. Of particular concern to the task force is the situation which exists for persons who are in need of long-term care but who cannot qualify financially. These individuals cannot qualify because their income is more than three times the Supplemental Security Income amount ($1,062), but insufficient to meet the costs of a nursing home. The adoption of a medically needy program will allow Medicaid benefits to be extended to those persons who are ineligible for cash assistance on the basis of income but whose income and resources are considered insufficient to meet their medical needs. Recognizing that a proposal for a medically needy program is being recommended by the Joint Review Committee for the Medically Indigent, the members of the task force decided against recommending legislation which might duplicate the efforts of that committee.

Estate recovery program. The Department of Social Services has concluded that an estate recovery program could be implemented in Colorado as a viable mechanism for Medicaid recipients to share in the costs of nursing home care. Task force members concurred that an estate recovery program would be an effective method of offsetting Medicaid costs, while promoting more equitable treatment of Medicaid recipients. The success of an estate recovery program is dependent upon: 1) the resolution of significant policy issues and options by the General Assembly, such as limitation of recoveries; and 2) whether an initial investment is made for adequate staffing, computer system enhancements, training, and other costs necessary to implement the program. Due to the limitation on the number of legislative recommen-

dations, the task force decided that this important issue should be set aside in favor of proposals of a more urgent nature.

LONG-TERM HEALTH CARE NEEDS OF SPECIAL POPULATIONS

The task force was directed to study the needs of special populations of persons requiring long-term health care. For example, these needs include respite care, rehabilitation services, job coaching, occupational, and physical therapy. Special populations include the chronically mentally ill, developmentally disabled, AIDS patients, disabled adults, Alzheimer's Disease patients, persons diagnosed with neurologic conditions, veterans, and the elderly vision impaired. Long-term health care needs for these special populations are significant, and changes are recommended in the delivery and availability of these services. The task force made the following major findings:

Finding #1 -- Increased funding is needed for community mental health services in order to serve the approximately 17,000 chronically mentally ill adults and elderly individuals who are currently not being served.

Finding #2 -- The Colorado developmental disabilities system is seriously threatened by an accelerating demand for new services and inadequate funding of present services.

Finding #3 -- The Medicaid rehabilitation option, in lieu of the clinic option, should be adopted for the delivery of mental health services.

Finding #4 -- An insurance plan for the uninsurable is needed to avoid the financial strain that the uninsured place on the health care system and to provide for the needs of those individuals requiring long-term health care.

Finding #5 -- A severe shortage of rehabilitation professionals exists in Colorado, especially physical and occupational therapists.

Finding #6 -- Existing disabled adult protection laws need to be strengthened by expanding the availability of protective services.

The Task Force Recommends:

Increased funding for community mental health. The task force studied the special needs of the chronically mentally ill population in terms of what services may be lacking and how gaps in services may be reduced. The Division of Mental Health estimates that 34,000 adult and elderly persons suffer from chronic mental illness in Colorado. Of that number, approximately 17,000 persons are receiving no services. The task force recommends that the General Assembly fund a five-year plan for community mental health. An appropriation will fund the first year of the plan, targeting those persons not being served and increasing and improving services for the underserved mentally ill. The plan will add staff and services in order to provide more adequately for those in rural areas, minorities, homeless mentally ill, persons with dual diagnoses, the elderly, and children.

Funding for developmentally disabled. The task force was directed to examine the long-term health care needs of persons with developmental disabilities. Community waiting lists of persons receiving no services has reached crisis proportions. This situation exists because of the lack of funding. Increased funding would reduce the existing waiting lists and keep pace with new demand. The task force requests that the General Assembly favorably act on the need for continued funding of the **Five-year Plan for Community Services for Persons with Developmental Disabilities.** The five year plan has two parallel goals to: 1) eliminate existing waiting lists (June 1989 waiting list for day services was 1,000 persons and for residential services was 1,293); and 2) ensure the quality and stability of existing community services through adequate funding. Objectives for the second year of the plan are to reduce existing waiting lists by 32 percent and increase funding of current services by six percent.

Medicaid rehabilitative services. Rehabilitative services are intended to reduce physical or mental disabilities and to restore the highest possible functional level to disabled individuals. These services, by definition, include any medical or remedial services recommended by a physician. Case management will be included as a remedial service. The state is currently utilizing the "clinic option" of Medicaid for the provision of services to Medicaid eligible mentally ill clients in the community mental health system. Under this option, services must be provided in a facility under the control of the mental health center. This requires all clients to come to a mental health center in order to receive service, and makes it difficult to provide services to treatment resistant clients, such as the homeless mentally ill.

The task force recommends that the Medicaid rehabilitation option be adopted for the delivery of mental health services in lieu of the clinic option. The rehabilitation option does not have the prohibition against off-site delivery of services. Therefore, clinicians could reach out to clients and provide services in more appropriate locations. Eligibility for these services will not change under the rehabilitation option,

and the recommendation has no fiscal impact. This recommendation will be introduced by an individual legislator during the 1990 session thus, it is not included as one of the task force bills.

Uninsurable health insurance plan. The projected number of elderly and disabled (those in need of long-term health care) is expected to double between the years 1980 and 2000. Many of these individuals are without health insurance and cannot obtain affordable health insurance coverage. Without some type of uninsurable health insurance plan, the impact on the state's obligation to the Medicaid program will surely grow in proportion to the expanding population of the elderly and disabled. The task force urges the passage of the Uninsurable Health Insurance Plan.

Eligibility criteria. Artificial barriers such as age should be removed, and instead equal access based on medical need should be provided to ensure inclusion of HIV infected patients. The task force recommends that eligibility criteria for accessing care and services be reviewed to ensure that exclusionary barriers unrelated to medical need for a service be eliminated.

Higher education programs. The task force recommends that the General Assembly direct the Colorado Commission on Higher Education to expand the number and size of professional training programs in rehabilitation and social care disciplines (there is only one program each for physical, occupational, and speech therapy in the state). In addition, the curricula for the state-supported institutions of higher education, as well as the Schools of Medicine and Nursing at the University of Colorado Health Sciences Center, should be expanded to include the long-term health care needs of those with neurological disabilities.

ALZHEIMER'S DISEASE

Alzheimer's Disease and related disorders is the fourth largest killer in the United States. The disease affects millions, and 120,000 Americans die of Alzheimer's Disease each year. Societal cost is close to $80 billion for Alzheimer's Disease and related disorders. There is no cure for Alzheimer's Disease, and there is a critical need for additional research in this area. Members of the task force recognize the state's limited ability to address all of the needs of its citizens who are unable to care for themselves, but also agree that if nothing is done to help Alzheimer's patients and their families, the state will face greater fiscal demands as the aging of our population and the incidence of dementia increases. According to the American Journal of Public Health, the prevalence of severe dementia in the over age 65 population ranges from 1.3 to 6.2 percent. The prevalence of dementia in the age group over 85 years may be as high as 20 percent. With 70 percent of Alzheimer's patients being cared for by families, and with approximately 50 to 60 percent of nursing home patients being victims of Alzheimer's disease or related disorders, the disease has an immense

impact on the family as well as on the Colorado economy. The task force made the following major findings:

Finding #1 -- The special needs of Alzheimer's Disease patients should be considered in the development of rules and regulations of a single entry point system.

Finding #2 -- Medical research offers the only hope for understanding and eventually eliminating Alzheimer's Disease and related disorders.

Finding #3 -- A member of the Alzheimer's Disease Subcommittee should be included as a member of the Department of Social Services' Long-Term Care Advisory Committee.

Finding #4 -- Respite care services are the greatest unmet need for Alzheimer's patients and their families.

The Task Force Recommends:

Single entry point. Since the task force recognizes that Alzheimer's Disease patients have special needs, the word "dementia" was added to the single entry concept recommendation (Bill 1). This addition to the bill requires that, in the development of the rules and regulations, the special needs of Alzheimer's Disease patients be considered. This addresses the need for a more intensive needs assessment for dementia patients.

Increased funding for research. The total obligations by all federal agencies for research on Alzheimer's Disease and related disorders have gone from $5.1 million in 1978 to $123.4 million in 1989. However, it has been estimated by the National Institute on Aging that for every $1.00 spent on Alzheimer's Disease, only $0.01 is spent on research. It is apparent that a much greater research effort is needed to bring research on Alzheimer's Disease in line with efforts in other comparable areas. Joint Resolution 1 urges Congress to increase federal support in order to address some of the major issues still surrounding Alzheimer's Disease and related disorders.

Membership on the Long-Term Care Advisory Committee. The interests of Alzheimer's Disease patients must be represented in the development of the state's long-term health care system. Therefore, the task force urges the Department of Social Services to include a member of the Alzheimer's Disease Subcommittee on the Department's Long-Term Care Advisory Committee. This will ensure that the special needs of Alzheimer's Disease patients are considered in the development of a single entry point system.

Respite care. Respite care relieves the burden of the family caregivers and prevents premature institutionalization of Alzheimer's Disease victims. If state funds are available, Alzheimer's Disease patients and their families will be better served by providing assistance in accessing such care rather than developing additional respite care programs that may not be needed.

QUALITY OF CARE

One of the long-term health care issues of great concern involves the quality of care. The task force found that, despite thorough state regulation of health care facilities, several areas need to be addressed to assure safety and increase the quality of life for individuals requiring long-term health care. The task force studied issues such as personal care boarding homes, long-term care health personnel shortages, nutrition, and other issues relating to the quality of care. The task force agreed that fundamental guiding principles must underlie planning and action by the legislature or state agency in the field of long-term health care. These principles include: quality services, access, an equitable and understandable system, client's rights, adequate and trained staff, responsible management, state protection, and establishment of a single entry point. The task force made the following major findings.

Finding #1 -- Bring Colorado's Ombudsman program in compliance with federal law.

Finding #2 -- Strengthen the funding mechanism for inspection and licensure of personal care boarding homes.

Finding #3 -- A health care provider shortage exists in the nursing and physical therapy professions and this has a critical impact on the quality of long-term health care.

Finding #4 -- Develop a nutritional assessment tool that will provide guidelines in determining nutritional status of an individual.

The Task Force Recommends:

Ombudsman program. The federal Older Americans Act encourages the development of comprehensive planning and the coordination of services for the elderly, including nutrition, health, housing, employment, transportation, information, and referral services. Eligibility for direct services is extended to all people aged 60 or older, without regard to income, but services are targeted to those with greatest need. Colorado's Long-Term Care Ombudsman is a representative of a public agency who investigates and resolves complaints made by or on behalf of older individuals who are residents of long-term care facilities. The 1987 amendments to the Older Americans Act provide additional protection for the Long-Term Care Ombudsman

and designated representatives. The new protections include immunity, access to facilities, and prohibition against willful interference with the ombudsman or person representing the office. Bill 2 would bring the state's program into compliance with federal law.

Personal care boarding homes. A critical shortage of affordable residential facilities exists in the community. Personal care boarding homes offer an alternative to nursing home placement and are generally less expensive. This is an emerging industry meeting a necessary community need and serving several populations in the continuum of long-term health care. A wide variety of personal care boarding homes are available from the small, home-like facilities to the larger more institutionalized facilities. With implementation of the Omnibus Budget Reconciliation Act of 1987, the chronically mentally ill are likely to live in personal care boarding homes because of the lack of residential alternatives. Personal care boarding homes must be safe places with proper oversight and residents must be appropriately placed and receive an adequate level of care. It is imperative that personal care boarding home facilities be regulated and required to follow the regulations established for the safety and welfare of the residents in these facilities. Under current regulations, the only enforceable sanction is terminating the personal care boarding home license or not issuing the license. The task force concludes that attention to personal care boarding homes must be a priority and that licensure procedures must be adequately funded. Bill 6 provides this additional regulatory oversight of personal care boarding homes.

Nutrition assessment. Adequate nutrition information helps to promote wellness and prevention of chronic disease. An assessment tool which can be administered by paraprofessionals needs to be developed. Guidelines would include weight loss, relationship to ideal weight, and physical factors preventing good nutrition. Recent Department of Health data from January 1989, comparing deficiencies and food costs, showed the amount spent on food in nursing homes did not necessarily relate to the nutritional value of the food provided.

In addition to the legislative proposals, the task force makes the following recommendations directed towards the Departments of Health, Institutions and Social Services and the University of Colorado School of Medicine.

Department of Social Services

1. Develop recommendations regarding licensure of home health agencies.
2. Develop a bill of rights for home care recipients.
3. Develop a consumer booklet on how to select a home health agency.
4. Monitor effectiveness of the nursing home sanctions law.

5. Recommend that the Long-Term Care Advisory Committee develop educational sessions for physicians involved in long-term care.

6. Work with the Department of Regulatory Agencies to produce an external evaluation of the nursing assistant training program.

7. Continue study of including home delivered meals as a reimbursable service under the home and community based services program.

Department of Health

8. Change Chapter V Regulations to allow residents three business days to file an appeal after receipt of a written notice for an involuntary transfer or room change.

9. Clarify definition of discharge and transfer as it pertains to nursing home to hospital transfers.

Department of Institutions

10. Establish a system for supporting chronically mentally ill residents in personal care boarding homes with case management and structured daily activities.

University of Colorado School of Medicine

11. Encourage a higher level of course work focusing on food and nutrition, especially as a preventative and restorative healing tool.

CONTINUUM OF LONG-TERM HEALTH CARE

A continuum of care means an organized system of care, benefits, and services to which a client has access and which enables a client to move from one level or type of care to another without encountering gaps or barriers. For example, case management, congregate meals, adult protection, dental care, financial management, homemaker services, respite care, and adult foster care are the kind of services found within a continuum of care. Providing a continuum allows more individuals to remain in their homes and communities, thus maximizing their independence and quality of life. It only provides necessary services, thereby reducing the cost of care to individuals. In order to determine whether any gaps exist along the continuum, the task force evaluated the need to integrate current programs into a continuum and to fill gaps in services that may be needed to complete a continuum of care. The task force concluded that gaps exist in the array of long-term care services.

Numerous problems confront persons trying to access long-term health care in Colorado. Individuals and families needing access to information or services to meet chronic long-term care needs often confront a confusing array of services provided by a variety of agencies under a number of different eligibility criteria. The delivery of services and programs appears to be fragmented and duplicative, with some programs working at cross purposes. Persons access the system from different entry points, and eligibility requirements often vary from program to program. Moreover, current service delivery focuses on nursing homes, while home and community-based alternatives may be more appropriate, more cost effective, and preferred over institutionalization. Being assessed for all long-term care needs at one time would make it easier for clients to access the most appropriate services and would link clients to the least costly service required to meet their needs. In addition, individuals could move between services more readily when their needs change without encountering gaps or barriers. The task force made the following major findings:

Finding #1 -- The largest continuum of care deficiency appears to be a lack of an organized system of care that links together the various services.

Finding #2 -- Colorado's current long-term care system should be restructured before making individual program recommendations or adding services, except for hospice care, which has a more immediate need and has proven to be cost effective.

Finding #3 -- A continuum of care provided to persons requiring long-term health care should be flexible with respect to movement along that continuum.

The Task Force Recommends:

Single entry point. The task force recommends the development of a single entry point and common assessment tool. This concept will better organize client entry, and assessment and service delivery by providing clients access to the full continuum of care services. Bill 1 includes the establishment of a single entry point in local areas for long-term health care. An important provision of the bill includes the implementation of a standardized client assessment procedure and an instrument to more appropriately and consistently target services to persons most in need. These changes would replace multiple forms and criteria now being utilized. Another feature of Bill 1 is targeted case management as a new Medicaid service in order to better manage existing programs and to capture additional federal resource through the refinancing of current state and local dollars.

Hospice care. The task force recommends that hospice care should be included as a service under the "Colorado Medical Assistance Act." Hospice care addresses the physical, spiritual, emotional, psychological, social, financial, and legal needs of the

dying patient and his or her family. Hospice care is provided by an interdisciplinary team of professionals and volunteers in a variety of settings, both inpatient and at home, and includes bereavement care for the family. Hospice care has been demonstrated to improve the quality of life by providing support and by controlling symptoms. This provides care which meets total needs of the patient and family members during the dying process. Bill 7 expands coverage of hospice care provided in the home or in an institutional setting for terminally ill persons. Hospice care means: "services provided by a public agency or private organization, or any subdivision thereof, which entity shall be known as a hospice and shall be primarily engaged in providing care to an individual for whom a certified medical prognosis has been made indicating a life expectancy of six months or less and who has elected to receive such care in lieu of other medical benefits."

CASE MANAGEMENT

Case management generally refers to the coordination of a continuum of services that enables clients to function effectively in the community. However, there is considerable latitude in the professional literature and in practice as to which services constitute case management and how services are organized into case management models. At one extreme is a "brokered" system in which a case manager contracts for services from a variety of agencies. At another extreme is a system in which the client's therapist provides the case management services directly.

The task force compared case management for the developmentally disabled, elderly, blind and disabled, chronically mentally ill, and others. They attempted to identify commonalities among the various case management areas by examining the structure, definition, functions, models, recruitment of case managers, and the consumer's point of view. The task force concluded that differences exist over the role and authority of the case manager, caseloads, rural and urban applications, outreach, access and screening. Thus, there is no available model designed to encompass the range of case management functions.

The passage of the single entry point concept will have an important impact on case management. Having a single entry point for all long-term health care services in each local area will reduce much of the confusion that now exists among clients, families, and health care providers. Assessing clients long-term health care needs at one time will speed the process and link clients to the least costly service required to meet their needs. The task force made the following major findings:

Finding #1 -- There are varying opinions as to what case management is and what is the most effective model and structure.

Finding #2 -- Case management may be developed as an independent system in which the case manager acts as an advocate for the individual and serves as a broker to locate and purchase appropriate services for the individual.

Finding #3 -- Case management is among the core services of a community support program for mentally disabled persons.

Finding #4 -- Long-term care clients have multiple needs which can be addressed only by a coordinated approach.

The Task Force Recommends:

Case management study. Bill 8 requires that the Governor select a department to conduct a case management study of disabled clients with mental impairments of the Departments of Institutions and Social Services. The department will be responsible for developing and administering a pilot project using a case management system for the delivery of services to specified disabled individuals. The task force recommends that the study be focused on an urban area of the state and that the project be conducted in a rural area. Furthermore, the case management system to be used for the pilot project should be an independent system which shall be designed by a project director appointed by the executive director of the designated department. An advisory committee will be created to:

- assist in conducting the study and in selecting a project director to design the case management system for the pilot project;
- make recommendations to the project director concerning the design of the independent case management system; and
- assist in evaluating the pilot project.

APPENDIX A

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5. Office of Technology Assessment, Losing a Million Minds: Confronting the Tragedy of Alzheimer's Disease and Other Dementias, Washington, D.C., April, 1987.

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8. State Demographer, Department of Local Affairs, State of Colorado.

9. "The Public Health Impact of Alzheimer's Disease," American Journal of Public Health, September, 1987.

TASK FORCE ON LONG-TERM HEALTH CARE

MEMBERS

Sen. Dottie Wham
Chairman

Rep. Norma Anderson
Vice Chairman

Sen. Dennis Gallagher
Rep. Wilma Webb

Arlan Anderson
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Dr. Bernard Nelson
Denny O'Malley
Darlene Park
Anita Sanborn
Tom Sangster
Youlon Savage
Mildred Simmons
Henry Solano
Bob Wilson

November 27, 1989

Members of the Joint Budget Committee
200 East 14th Avenue
Legislative Services Building
Denver CO 80203

Dear:

One of the recommendations from the Legislative Task Force on Long-Term Health Care concerns the development of a single entry point for long-term health care services. A single entry point is a designated agency in a local community which all elderly and disabled clients can use to obtain access to needed long-term care services. The advantage of having one well-defined place to go to obtain access to the entire range of long-term care services is to reduce confusion for potential clients, their families, and the provider community. An additional improvement to the long-term care system would involve the use of advanced computer technology to improve the coordination of the eligibility application and determination process. This technology may allow eligibility determination to be co-located at the single entry point if necessary. As part of their budget initiative, the Department of Social Services has recommended the purchase of "Expert System" software.

This "Expert System" software can be used to more efficiently determine various human services program eligibility such as AFDC, food stamps, and Medicaid, and can be expanded to the Medicare and Supplemental Security Income programs. All state and federal statutes and rules and regulations that impact social services programs would be contained in the system. By utilizing this technology, a person could quickly determine what programs a client might be eligible for. Several advantages of the "Expert System" include:

-- enhancing single entry;
-- promoting standardization, and allowing every county or region to have the same information and access;
-- promoting uniformity by providing equal access for all citizens;
-- eliminating or reducing appeals;
-- reducing administrative costs; and
-- allowing for the private sector to contract for this service.

On behalf of the members of the Legislative Task Force on Long-Term Health Care, I would urge the Joint Budget Committee to favorably act on funding the Department of Social Services' request for the newly developed "Expert System" software package. It is our understanding that this request has been approved by the Information Management Commission as a budget initiative from the Department of Social Services.

Sincerely,

Senator Dottie Wham, Chairman
Legislative Task Force on Long
Term Health Care

TASK FORCE ON LONG-TERM HEALTH CARE

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Mildred Simmons
Henry Solano
Bob Wilson

December 14, 1989

Members of the Joint Budget Committee
Legislative Services Building
200 East 14th Avenue
Denver, CO 80203

Dear Members:

As part of its broad charge, the Legislative Task Force on Long-Term Health Care studied the special needs of the chronically mentally ill population in terms of what services may be lacking and how the gaps in services might be reduced.

After careful review of the extensive and comprehensive data and information gathered during the more than thirty hearings conducted by the Subcommittee on the Chronically Mentally Ill, the Task Force recommends an increase of $8.6 million in fiscal year 1990-91. This appropriation would fund the first year of a five year plan for community mental health services, targeting those persons not now being served and increasing and improving services for the under-served mentally ill.

The increase in funding would add staff and services required to reach out to the approximately 17,000 chronically mentally ill adults and older persons not currently being served, and to provide more adequately for persons in rural areas, minorities, homeless mentally ill, persons with dual diagnoses, the elderly, and children and youth.

On behalf of the members of the Legislative Task Force on Long-Term Health Care, I urge the Joint Budget Committee to favorably act upon this recommendation.

Sincerely,

Dottie

/s/ Senator Dottie Wham, Chairman
Task Force on Long-Term Health Care

TASK FORCE ON LONG-TERM HEALTH CARE

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November 27, 1989

Members of the Joint Budget Committee
200 East 14th Avenue
Denver, CO 80203

Dear Members:

The Legislative Task Force on Long-Term Health Care studied the need for the development and support of a well organized, managed and controlled long-term health care system in the state and is recommending legislation to improve Colorado's long-term health care system. Within this study charge was an examination of the long-term care needs of special populations, including those of persons with developmental disabilities.

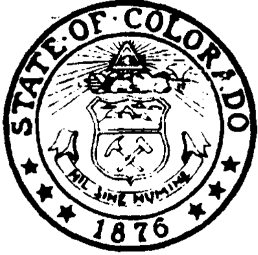
The Task Force requests that the Joint Budget Committee favorably act on the need for continued funding of the **Five-year Plan for Community Services for Persons with Developmental Disabilities, Colorado Community Challenge**. The goals of the plan are: 1) to eliminate existing waiting lists (June, 1989 waiting list for day services was 1000 persons and for residential services was 1293); and 2) to insure the quality and stability of existing community services through adequate funding. Objectives for Year 2 of the plan are to reduce existing waiting lists by 32 percent and increase funding of current services by 6 percent. Incorporating the unfunded portion of the Year 1 request, the total general fund request for the second year is $13 million.

On behalf of the members of the Legislative Task Force on Long-Term Health Care, I urge the Joint Budget Committee to favorably act on this issue concerning the needs of persons with developmental disabilities in communities across Colorado.

Sincerely,

Dottie

Senator Dottie Wham, Chairman
Task Force on Long-Term Health Care



TASK FORCE ON LONG-TERM HEALTH CARE

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Bob Wilson

November 27, 1989

Senator Claire Traylor
4045 Field Drive
Wheat Ridge CO 80033

Dear Senator Traylor:

The Legislative Task Force on Long-Term Health Care has recently concluded its eighteen month study of the long-term care health care needs in the state of Colorado. One of the disturbing facts disclosed during those deliberations is that the projected number of elderly and disabled (those in need of long-term health care) is expected to double between the years 1980 and 2000. Many of these individuals are without health insurance and cannot obtain affordable health insurance coverage. Without some type of uninsurable health insurance plan, the impact on the state's obligation to the Medicaid program will surely grow in proportion to the expanding population of the elderly and disabled. The Task Force concluded that an insurance plan for the uninsurable is desirable to avoid the financial strain that the uninsured place on the health care system and to provide for the needs of those individuals requiring long-term care. Therefore, in addition to the legislative recommendations proposed by the Task Force, the members recommend that the Second Regular Session of the Fifty-Seventh General Assembly approve the Uninsurable Health Insurance Plan, that we understand will be reintroduced by you in 1990.

Society bears the brunt of the cost of inadequate protection for health expenses. This can be in the form of lower employee productivity or through the growing debt of uncompensated medical care, which results in increased costs of health insurance for those that can afford such costs. Also, the scarcity of dollars for health care forces increased competition among clients of the health care system. The issue presented is how can the state most equitably spread the expense and meet the health care needs of the uninsured at the same time. The Task Force recognizes the many advantages of your proposal, such as:

-- prevention against depletion of savings needed for long-term health care; and

-- prevention against medical disasters and impoverishment of individuals.

Members of the Task Force concluded that insurance should be made available to those "uninsurable" Colorado residents who have been denied health insurance coverage for reasons of poor health or medical

condition; have been accepted for insurance but with policies requiring extremely high premiums; or suffer from a medical or health condition appearing on a list of impairments or conditions requiring waivers developed by insurance underwriters.

The members also share in the belief that is it unfair when people who have insurance while they are healthy are denied the opportunity to keep their insurance after a chronic illness occurs or are denied the opportunity to obtain other comparable insurance.

Therefore, the members of the Legislative Task Force on Long-Term Health Care urge passage of the Uninsurable Health Insurance Plan. On behalf of the members of the task force, I wish you well with this proposal in the upcoming session.

Sincerely,

Senator Dottie Wham, Chairman
Task Force on Long-Term Health Care

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December 15, 1989

Senator Alvin Meiklejohn
Chairman
Interim Committee on Higher Education
7540 Kline Drive
Arvada, CO 80005

Dear Senator Meiklejohn:

The Legislative Task Force on Long-Term Health Care recently concluded its 18 month study. As part of its broad charge, the task force studied the impact of the patient care practitioner shortage on long-term care. One of its conclusions was that a severe shortage of health care practitioners exists in the nursing and physical therapy professions and that this shortage may have a critical impact on the quality of long-term health care in Colorado. With the elderly and disabled in need of long-term care support expected to double from 1980 to the year 2000, the importance of addressing such needs as soon as possible appears to be even more crucial.

The purpose of this letter is twofold. First, to ask that the General Assembly direct the Colorado Commission on Higher Education to expand the number and size of professional training programs in rehabilitation and social care disciplines in order that registered nurses and licensed professional nurses can obtain knowledge and skills applicable to long-term health care. Such courses would not only produce nurses with updated applicable skills but also legitimize the special knowledge and skills required to deliver quality care in long-term care facilities. A crucial factor impacting the quality of life of residents in long-term health care facilities is the availability of effective nursing care. A 1988 Health and Human Services Report of Nursing estimates that, by the year 2020, there will be a 68 percent growth for registered nurses in hospitals and 132 percent growth for registered nurses in nursing homes.

In addition, the perceived quality of life of residents in long-term care facilities is greatly dependent upon the limiting of any physical disabilities and maximizing of existing abilities associated with daily living. Thus, our second request is to ask that the General Assembly address the shortage of physical therapists in the state by directing the Colorado Commission on Higher Education to increase the number of persons graduating from in-state physical therapy education programs.

Colorado's acute shortage of physical therapists was first brought to the General Assembly's attention in October 1987, when rural hospitals were encountering severe problems in their efforts to recruit physical therapists. At about the same time, many of the state's certified home health agencies which had traditionally contracted with individual physical therapists to provide physical therapy services in their clients' homes, began to notice an inadequate supply of physical therapists. This shortage has become so aggravated that many home health agencies are now unable to provide physical therapy to the state's Medicaid home health population. This could possibly put our state's Medicaid program in jeopardy with the federal government.

A recent survey showed 86 full time equivalent physical therapy positions vacant in hospitals, home health agencies and private practice throughout the state. The only physical therapy educational program in the state is at the University of Colorado Health Sciences Center, which graduates approximately 35 persons a year. Class size is limited by the number of faculty, physical space, money, and clinical resources. There is an obvious need to support expansion of the program and encourage utilization of long-term care facilities for clinical experiences. In addition, other higher educational institutions should be encouraged to explore instituting a new program, such as a consortium-type physical therapist assistant education program.

The members of the task force urge the General Assembly to address this severe shortage of professional programs in these critical professions by directing the Colorado Commission on Higher Education to further expand programs in size and number in order to help alleviate the nursing and physical therapist provider shortage.

Sincerely,

Senator Dottie Wham, Chairman
Task Force on Long-Term Health Care

TASK FORCE ON LONG-TERM HEALTH CARE

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December 4, 1989

Ms. Irene Ibarra, Executive Director
Colorado Department of Social Services
Social Services Building, 8th Floor
1575 Sherman Street
Denver, Colorado 80203

Dear Ms. Ibarra:

As you are aware, the Legislative Task Force on Long-Term Health Care recently concluded its eighteen month study of Colorado's long-term health care system. Numerous recommendations were made to the task force by its six subcommittees to address various concerns. However, despite the task force's broad charge, a legislative rule limits the task force to only eight legislative recommendations for the 1990 session. As a result, not all subcommittee recommendations were given final approval, and several subcommittee recommendations were combined into single proposals.

The task force's Alzheimer's Disease Subcommittee recommended a proposal that would have created Alzheimer's Disease regional centers throughout the state to serve the special needs of Alzheimer's patients. To reduce possible duplication of programs with the single entry point proposal and to also accommodate for the bill limitation, the Alzheimer's Disease Subcommittee agreed to withdraw its regional center proposal with two conditions.

First, the task force agreed to amend the department's single entry point proposal by addressing the need for a more intensive needs assessment for dementia patients. Second, the task force agreed to urge the department to allow for Alzheimer's Subcommittee representation on its Long-Term Care Advisory Committee.

Therefore, on behalf of the Long-Term Health Care Task Force and its Alzheimer's Disease Subcommittee, I urge the Department of Social Services to allow an Alzheimer's Subcommittee member to serve on the department's Long-Term Care Advisory Committee. This would ensure special needs of Alzheimer's patients are considered in the development of a single entry point system. The Alzheimer's Disease Subcommittee recommends that Anita Sanborn of the Alzheimer's Disease and Related Disorder Association be designated as its representative.

Sincerely,

Dottie

Senator Dottie Wham, Chairman
Task Force on Long-Term Health Care

LONG TERM CARE INVENTORY

OVERVIEW

(Compiled by Departments of Health, Institutions, and Social Services)

- The following tables provide an overview of long term care services which are provided through the Departments of Health, Institutions, and Social Services. The package is organized into four segments:

I. Long Term Care - Client Profiles (pages 1 - 6)

II. Long Term Care - Regulation and Oversight (pages 7 - 11)

III. Long Term Care - Direct Client Services (pages 12 - 14)

IV. Long Term Care - Contractual Services (pages 15 - 17)

- This package represents a first step in the compilation of an inventory of Long Term Care Services. It is intended that this be refined and updated over time. In reviewing this information two notations are important:

  (1.) In client profiles, the portion which is performed by the Department of Health provides facility counts rather than individual client counts.

  (2.) Because Social Services is the Medicaid single state agency, the General Fund/Federal Fund appropriations for Medicaid Services are made to Social Services and then Medicaid cash funds are appropriated to the Departments of Health and Institutions.

- Finally, the approximate Total Dollars appropriated in the state system for Long Term Care follow:

	REGULATION AND OVERSIGHT	DIRECT CLIENT* SERVICES	CONTRACT CLIENT SERVICES	FY 89-90 GRAND TOTAL APPROPRIATION	FTE
T	$6,399,216	$202,112,011	$238,290,645	$446,801,872	3,615.3
GF	2,209,512	118,570,141	129,230,403	250,010,056	
CF	156,679	62,753,041	2,962,258	65,871,978	
FF	4,033,025	20,788,829	106,097,984	130,919,838	

* Allocates Medicaid Cash Funds to General Funds and Federal Funds.

LONG TERM CARE - CLIENT PROFILES
(NOTE: Focus for Department of Health is facility counts, not individual client counts)

DEPARTMENT HEALTH

AGENCY HEALTH FACILITIES DIVISION

POPULATION DESCRIPTION/ CHARACTERISTICS	ESTIMATED POPULATION IN NEED	# NOW SERVED IN MEDICAID (# FACILITIES)	# NOW SERVED IN OTHER STATE APPRO. PROGRAMS	# THROUGH OTHER FUND SOURCES	# WHOSE NEEDS ARE UNMET
Skilled Nursing Care Facilities - 169 facilities		Medicaid/Medicare Medicaid		Private 9 Medicare only -11	Private Pay patients
Intermediate Care Facilities - 31 facilities		28		Private - 3	Private Pay patients
Facilities for the Mentally Retarded RCFDD - 156 facilities ICFMR - 9 facilities RCFMI - 42 facilities		° 156 licensed/pending ° 9 licensed ° 42 licensed - 11 pending	156 DOI 42 DOI		
HCBS - EBD 98 facilities certified PC/HM - 61 ADC - 26 R/NH - 11 274 clients were monitored in 88/89 ACF - 52 facilities surveyed 167 clients were monitored Need to access # of beds certified	No license licensed under PCBH	certified DSS certified DSS -52			
PCBH - 141 Licensed facilities (52 are ACF) 59 Surveyed or in process 56 Ready for Survey 35 Incomplete applications		Not certified		HFD - licensed for bed fee	
Needs assessment # of beds.					
Elderly, Blind, Disabled Clients assessments - 305 facilities - 102 revisits - 8					

LONG TERM CARE - CLIENT PROFILES

DEPARTMENT HEALTH

AGENCY HEALTH FACILITIES DIVISION

POPULATION DESCRIPTION/ CHARACTERISTICS	ESTIMATED POPULATION IN NEED	# NOW SERVED IN MEDICAID (# FACILITIES)	# NOW SERVED IN OTHER STATE APPRO. PROGRAMS	# THROUGH OTHER FUND SOURCES	# WHOSE NEEDS ARE UNMET
Developmental Disability Client Assessments - 600 facilities - 80 revisits - 6					
Alternative Care Facility Clients Monitored - 200 facilities - 75 revisits - 9					
Licensure and Certification (facilities) Licensure only (including PCBH) surveys - 225 Licensure and Medicare survey - 155 Licensure and Medicaid - 113 Licensure - Medicare and Medicaid - 143 Medicare only survey - 311		113 facilities			
RESIDENT/RECORD ASSESSMENTS			13,000		

LONG TERM CARE - CLIENT PROFILES

DEPARTMENT INSTITUTIONS

AGENCY DIVISION FOR DEVELOPMENTAL DISABILITIES

POPULATION DESCRIPTION/ CHARACTERISTICS	ESTIMATED POPULATION IN NEED	# NOW SERVED IN MEDICAID (# FACILITIES)	# NOW SERVED IN OTHER STATE APPRO. PROGRAMS	# THROUGH OTHER FUND SOURCES	# WHOSE NEEDS ARE UNMET
Individuals with Development Disabilities are those diagnosed as having a developmental disability according to statutorily defined criteria. Colorado Revised Statute (CRS) 27-10.5-102 (10)(a) defines a developmental disability as a disability which: 1) is manifested before the person reaches twenty-two years of age; 2) constitutes a substantial handicap to the affected individual; and; 3) is attributable to mental retardation or related conditions which include cerebral palsey, epilepsy, autism or other neurological conditions when such conditions result in impairment of general intellectual functioning and adaptive behavior similar to that of mentally retarded persons. Pursuant to CRS 27-10-1-2(10)(b), persons less than five years of age who are at risk of having a developmental disability and who require treatment of services similar to those required by persons who are mentally retarded are also considered to be eligible for services.	35,861	2,407*	4,229*	-0-	29,225

* Includes only persons served by Division for Developmental Disabilities.

LONG TERM CARE - CLIENT PROFILES

DEPARTMENT INSTITUTIONS

AGENCY DIVISION OF MENTAL HEALTH

POPULATION DESCRIPTION/ CHARACTERISTICS	ESTIMATED POPULATION IN NEED	# NOW SERVED IN MEDICAID (# FACILITIES)	# NOW SERVED IN OTHER STATE APPRO. PROGRAMS	# THROUGH OTHER FUND SOURCES	# WHOSE NEEDS ARE UNMET
Individuals with Chronic Mental Illness To have chronic mental illness a person must have a severe and disabling mental illness and this condition must have lasted at least one year. In most cases, the illness is a lifelong condition.	34,529	4,480	6,720*	5,800**	17,000

* Served by the community mental health centers and clinics.
** Served by the private sector.

LONG TERM CARE - CLIENT PROFILES

DEPARTMENT SOCIAL SERVICES

AGENCY MEDICAL ASSISTANCE DIVISION

POPULATION DESCRIPTION/ CHARACTERISTICS	ESTIMATED POPULATION IN NEED	# NOW SERVED IN MEDICAID/MEDICARE	# NOW SERVED IN OTHER STATE APPRO. PROGRAMS	# THROUGH OTHER FUND SOURCES	# WHOSE NEEDS ARE UNMET
° Class I Nursing Homes - Elderly, Blind and Disabled clients in need of Skilled or Intermediate nursing home care.	14,937*	10,467	N/A	4,228**	N/A
° Class II Nursing Homes-Developmentally Disabled (non-DOI)	278*	273	N/A	5*	N/A
° Class IV Nursing Home (non-DOI) Developmentally Disabled clients	55*	55	N/A	N/A	N/A
° Class V Nursing Home - Physically disabled clients	34*	28	N/A	6*	N/A
° Home and Community Based Service Program - Elderly, Blind, and disabled	N/A	4, 453	N/A	N/A	N/A
° Home Care Allowance	N/A	N/A	4,952	N/A	N/A
° Adult Foster Care	N/A	N/A	436	N/A	N/A

* SOURCE: Nursing Home census data, May 1989.

** Private Pay

LONG TERM CARE - CLIENT PROFILES

DEPARTMENT SOCIAL SERVICES

AGENCY STATE NURSING HOME DIVISION

POPULATION DESCRIPTION/ CHARACTERISTICS	ESTIMATED POPULATION IN NEED	# NOW SERVED IN MEDICAID****	# NOW SERVED IN OTHER STATE APPRO. PROGRAMS	# THROUGH OTHER FUND SOURCES	# WHOSE NEEDS ARE UNMET
° Trinidad State Nursing Home Serves qualified Coloradans over 60 years of age.	192	124	68*	N/A	N/A
° Colorado State Veterans Center - Homelake	119	19	100**	N/A	N/A
° Colorado State Veterans Nursing Home - Florence	116	6	110***	N/A	N/A
° State Veterans Nursing Home at Rifle	96	14	82***	N/A	N/A

* Patient Pay
** General Fund, Patient Pay and Federal Veterans Administration Payments
*** Patient Pay and Federal Veterans Administration Payments
**** Approximate, based on funding split in Appropriation Report.

LONG TERM CARE - REGULATION AND OVERSIGHT

DEPARTMENT HEALTH

AGENCY HEALTH FACILITIES DIVISION

TITLE OF FUNCTION	DESCRIPTION OF FUNCTION	FY 89-90 APPROPRIATION	# OF FTE
FTE Overview	Administration Nursing Home Review Surveys Conducted - 1,128 Follow-up Visits - 439 Complaint Investigations - 491 Assessment of DD Clients - 1,510 Resident/Record Assessments - 13,000		26.9 46.7
Total FTE - Department of Health		Cash funds appropriation from Department of Social Services, Medicaid, Facility Certification See page 11.	73.6

LONG TERM CARE - REGULATION AND OVERSIGHT

DEPARTMENT INSTITUTIONS

AGENCY DIVISION OF DEVELOPMENT DISABILITIES

TITLE OF FUNCTION	DESCRIPTION OF FUNCTION	FY 89-90 APPROPRIATION	# OF FTE
° Group Home Licensure	Reviews of group homes under the HCB-DD program are conducted in conjunction with the Colorado Department of Health. CDH and DDD alternate site visits to all 157 group homes every other year.	T $88,471 MCF** 88,471	2.0
° Quality Assurance on-site review of community centered boards and approved service agencies	Division staff conduct comprehensive on-site review of agencies approximately once every 2 1/2 years to ascertain compliance with rules and standards for case management services, behavioral intervention practices, administration, family resource services, community integrated employment services and non licensed residential services. There are approximately 800 separate sites (exclusive of licensed group homes) where services are being provided.	T $186,268 MCF**186,268	4.0
° National Accreditation	Adult day programs are required to obtain accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF).	T $25,700 GF 25,700	
° Technical Assistance and Training	Community agencies receive technical assistance from division staff to correct deficiencies cited during on-site review. Training funds are allocated annually to community agencies to assist them in obtaining outside consultation.	T $80,493 MCF* 80,493	0.5* (non-add)
° Designation of community centered boards and approval of service agencies.	In accordance with statutory requirements, CCB's are annually designated by the Division. An application for designation is completed and reviewed prior to January 1 of each year. Service agencies are approved by the Division through a similar process; however, annual updates are required instead of full applications.	T $62,885 MCF** 62,885	1.0

* This FTE coordinates training and is included in the Quality Assurance item on this page.
** Medicaid Cash Funds

LONG TERM CARE - REGULATION AND OVERSIGHT

DEPARTMENT INSTITUTIONS

AGENCY DIVISION FOR DEVELOPMENTAL DISABILITIES

TITLE OF FUNCTION	DESCRIPTION OF FUNCTION	FY 89-90 APPROPRIATION	# OF FTE
° Regional Center internal oversight	As a provider of services, the Division has responseibility to internally evaluate the services delivered by the three regional centers to assure continuing compliance with state and federal requirements.	T $51.256 MCF** 51,256	2.0
° Other	In addition to those functions listed above, the handling of client appeals, complaint investigation, long range planning for quality assurance, and granting of waivers of rules and regulation is accomplished by FTE assigned to regulatory positions.		Included in total FTE
TOTAL: (Does not include Medicaid cash funds because this would be a double count of expendituresin the total system. The Medicaid dollars counted with the Department of Social Services information.)		T $25,700 GF 25,700	9.0

** Medicaid Cash Funds.

LONG TERM CARE - REGULATION AND OVERSIGHT

DEPARTMENT INSTITUTIONS

AGENCY DIVISION OF MENTAL HEALTH

TITLE OF FUNCTION	DESCRIPTION OF FUNCTION	FY 89-90 APPROPRIATION	# OF FTE
Program Services - sight assessments of all agencies.* Sight assessment includes all mental health centers and clinics and all 27-10 designated agencies.	Provide oversight and sight review of 58 agencies to insure compliance with all standards, rules, regulations and policies of the Division of Mental Health.	T 227,419 GF 97,790 FF 129,629	5.0
Medicaid monitoring	Provide review of all clinic option providers to ensure compliance with all State and Federal rules, regulations, and statutes pertaining to Medicaid.	T 232,992 MCF**232,992	5.0
TOTAL: (Does not include Medicaid Cash Funds in total because this would represent a double count of the total dollars in the system. This will be provided in the Department of Social Services information.)		T $227,419 GF 97,790 FF 129,629	10.0

* Agencies include community mental health centers and clinics, hospitals and nursing homes.
** Medicaid cash funds.

LONG TERM CARE - REGULATION AND OVERSIGHT ACTIVITY

DEPARTMENT SOCIAL SERVICES

AGENCY MEDICAL SERVICES/STATE NURSING HOME DIVISION

TITLE OF FUNCTION	DESCRIPTION OF FUNCTION	FY 89-90 APPROPRIATION	# OF FTE
° Nursing Home Audits	Financial Audits for each nursing home - contractual service.	T $457,200 GF 228,600 FF 228,600	N/A
° Home and Community Based Services Administration - for Elderly, Blind and Disabled.	Provides program administration, client assessments, facilities assessments.	T $1,300,357 GF 646,620 CF 3,559 FF 650,178	16.5
° Development of a Long Term Care Assessment Instrument	Through a grant from the Colorado Trust, the Department of Social Services is developing a long term care assessment instrument which will better align clients to long term care services.	T $ 80,000 CF 80,000	N/A
° Facility Certification - Nursing Homes	Provides two services - a. Inspection of Care through the Health Department. b. Peer Review Organization assessment of clients for nursing home services.	T $3,232,920 GF 960,177 FF 2,272,743	N/A
° Preadmission and Resident Assessments due to Nursing Home Reform Act (OBRA'87)	OBRA'87 requires nursing home client assessments for mental illness and developmental disabilities. Coordinated with Department of Institutions.	T $1,002,500 GF 250,625 FF 751,875	N/A
° State Nursing Home Division	State Administration of State Nursing Homes.	T $ 73,120 CF 73,120	1.0
TOTAL		T $6,146,097 GF 2,086,022 CF 156,679 FF 3,903,396	17.5

LONG TERM CARE - DIRECT CLIENT SERVICES

DEPARTMENT INSTITUTIONS

AGENCY DIVISION OF MENTAL HEALTH

LONG BILL LINE ITEM/S OR PROGRAM	DESCRIPTION OF SERVICE	# OF CLIENTS SERVED/YEAR	FY 89-90 APPROPRIATION	# OF FTE
Colorado State Hospital	State administered, hospital based mental health services. Services include inpatient hospital-based psychiatric care for children, adolescents, adults, elderly and forensic clients. Services also include general inpatient and surgical care for Department of Institutions and Department of Corrections clients	4,680	T 47,546,174 GF 33,353,651 MCF* 5,375,000 CF 8,817,523 FF -0- NET GF 35,956,092	1,308.7
Fort Logan Mental Health Center	State administered, hospital based mental health services. Services include inpatient hospital-based psychiatric care for children, adolescents, adults, and elderly clients.		T 21,506,909 GF 11,837,463 MCF* 5,888,540 CF 3,780,906 FF -0- NET GF 14,688,547	555.0
TOTAL: (Does include Medicaid Cash Funds.	These are not shown with DSS information.)		T $69,053,083 GF**50,644,639 CF 12,598,429 FF** 5,810,015	1863.7

* Medicaid Cash Funds.
** Includes GF and FF Appropriation to DSS.

LONG TERM CARE - DIRECT CLIENT SERVICES

DEPARTMENT INSTITUTIONS

AGENCY DIVISION FOR DEVELOPMENTAL DISABILITIES

LONG BILL LINE ITEM/S OR PROGRAM	DESCRIPTION OF THE SERVICE	# OF CLIENTS SERVED/YEAR	FY 89-90 APPROPRIATION	# OF FTE
Institutional Programs	The three state Regional Centers at Grand Junction, Pueblo, and Wheat Ridge provide 24 hour care through basic residential services, active treatment programs based on individualized assessments and habilitation plans, and medical care to persons with developmental disabilities.	769	T 38,549,225 GF 950,792 MCF** 35,684,124* CF 2,014,309 NET GF 18,228,153	1,299.6
Community Services	Community Day programs provide both habilitative and vocational services to person with developmental disabilities. Community Residential programs provide a wide range of services on a continuous basis apart from day services. Included within community residential services are; residential care; respite care; follow-along support services; and family resource services. Medicaid funds home and community based services under two waivers--one as an alternative to ICF/MR care (HCB-DD) and one as an alternative for developmentally disabled persons in Class I nursing homes.	5,867	T 79,459,125 GF 28,123,602 MCF** 40,196,421 CF 11,139,102 NET GF 47,570,248	
TOTAL: Does include Medicaid Cash Funds but breaks them out as they are appropriate to DSS as General Fund and Federal Funds.		5,867	T $122,962,494 GF 67,664,481 CF 42,144,602 FF 13,153,411	1,299.6

* Class IV Regional Center revenue in FY 1989-90 is appropriated at $42,388,584 of which $20,523,493 is General Fund. Of this amount, an additional $3,854,144 ($1,866,080 GF) will be expended directly by the Regional Centers. This is included in the total.

** Medicaid Cash Funds.

*** Includes General Fund and Federal Fund Appropriation to DSS called Medicaid Cash Funds.

LONG TERM CARE - DIRECT CLIENT SERVICES

DEPARTMENT SOCIAL SERVICES

AGENCY STATE NURSING HOME DIVISION

LONG BILL LINE ITEM/S OR PROGRAM	DESCRIPTION OF THE SERVICE	# OF CLIENTS SERVED/YEAR	FY 89-90 APPROPRIATION	# OF FTE
° Trinidad State Nursing Home	State operated nursing home.	192	T $3,709,737 CF 3,709,737	124.1
° Colorado State Veterans Center at Homelake	State operated nursing home.	119	T $1,671,960 GF 261,021 CF 1,033,479 FF 377,460	51.3
° State Veterans Nursing Home at Florence	State operated nursing home.	116	T $2,486,336 CF 1,661,855 FF 824,481	86.5
° State Veterans Nursing Home at Rifle	State operated nursing home.	96	T $2,228,401 CF 1,604,939 FF 623,462	80.0
TOTAL			T $10,096,434 GF 261,021 CF 8,010,010 FF 1,825,403	341.9

LONG TERM CARE - CONTRACTUAL SERVICES

DEPARTMENT INSTITUTIONS

AGENCY DIVISION OF MENTAL HEALTH

TITLE OF LONG BILL LINE ITEM OR PROGRAM	DESCRIPTION OF SERVICE	# OF CLIENTS/YEAR (IF KNOWN)	FY 89-90 APPROPRIATION
Community Programs	Contractual Purchase of Services. Community based mental health services.	11,200	T 44,631,208* GF 21,110,675 MCF** 18,867,676 CF 1,502,718 FF 3,150,139 NET GF 30,245,932
TOTAL (Does allocate Medicaid Cash Funds to General Fund and Federal Funds)			T $44,631,208 GF 30,245,932 CF 1,502,718 FF 12,882,558

* Includes funds for services to non-CMI clients.
** Medicaid cash funds.

LONG TERM CARE - CONTRACT SERVICES

DEPARTMENT SOCIAL SERVICES

AGENCY MEDICAL ASSISTANCE DIVISION

TITLE OF LONG BILL LINE ITEM OR PROGRAM	DESCRIPTION OF THE SERVICE	# OF CLIENTS/YEAR (IF KNOWN)	FY 89-90 APPROPRIATION
° Care for Persons in Nursing Homes (3,662,097 patient days)	Class I Nursing Home Care.	10,467 (Medicaid/Medicare)	T $151,574,195 GF 72,117,312 CF 1,021,810 FF 78,435,073
° Home and Community Based Services (Elderly, Blind and Disabled) - Case Management and Client Services.	Case Management, Home Health Care, Personal Care, Homemaker Services for Elderly, Blind and Disabled clients.	4,453	T $17,708,690 GF 8,512,902 FF 9,195,788
° Home Care Allowance	Not a Medicaid Service but providers homemaker and personal care services to clients in order to allow them the support services necessary to remain in their own homes.	4,952	T $12,577,323 GF 12,178,935 CF 398,388
° Adult Foster Care	Residential placement option for Elderly, Blind and Disabled clients.	436	T $928,877 GF 889,535 CF 39,342
° Home Health Care	Approximately half of the clients served and half the dollars are for long term care clients.	782	T $2,461,955(approx.) GF 1,230,977 FF 1,230,978
° Mental Health Component of Class I Nursing Homes	Provides mental health care for clients served in Class I nursing homes. These services are provided through the Department of Institutions.	N/A	T $206,000 GF 99,740 FF 106,260
° Treatment of Mentally Ill Clients due to OBRA'87	OBRA'87 requires treatment of mentally ill clients who are in nursing homes. These services are provided in coordination with the Department of Institutions.	N/A	T $820,781 GF 397,402 FF 423,379
° Class II and Class IV nursing home care	Purchases nursing home care for developmentally disabled clients.	328	T $7,381,616 GF 3,557,668 FF 3,823,948

LONG TERM CARE - CONTRACT SERVICES

DEPARTMENT SOCIAL SERVICES

AGENCY MEDICAL ASSISTANCE DIVISION (Continued)

TITLE OF LONG BILL LINE ITEM OR PROGRAM	DESCRIPTION OF THE SERVICE	# OF CLIENTS/YEAR (IF KNOWN)	FY 89-90 APPROPRIATION
TOTAL: (Excludes lines which are included in DOI information in order to avoid double counting expenditures.)			T $193,659,437 GF 98,984,471 CF 1,459,540 FF 93,215,426

BILL 1

A BILL FOR AN ACT

1 CONCERNING A REORGANIZATION OF SERVICE DELIVERY FOR PERSONS IN
2 NEED OF LONG-TERM CARE THROUGH A SINGLE-ENTRY POINT
3 SYSTEM, AND, IN CONNECTION THEREWITH, ADOPTING A UNIFORM
4 ASSESSMENT INSTRUMENT.

Bill Summary

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

Requires the state department of social services to develop and implement a long-term care uniform client assessment instrument to determine appropriate services and levels of care to meet clients' needs and the payment sources for such care and to assist private paying clients in selecting long-term care services that best meet clients' needs.

Requires the state department of social services to conduct a comprehensive study of the establishment of centralized systems at the local level for disseminating long-term care information, for consolidating long-term care resources, for assessing individuals' long-term care needs, and for delivering appropriate long-term care under a plan of care which includes case management. Specifies components of such study. Requires the department to report the findings from such study to the general assembly.

---

5 Be it enacted by the General Assembly of the State of Colorado
6 SECTION 1. Article 4.5 of title 26, Colorado Revised

1 Statutes, 1989 Repl. Vol., is amended BY THE ADDITION OF A NEW
2 PART to read:

3 PART 4

4 LONG-TERM CARE PLACEMENTS

5 26-4.5-401. Legislative declaration. (1) The general
6 assembly hereby finds, determines, and declares that there is
7 an increasing strain on long-term care services in the state;
8 that the number of persons in need of long-term care continues
9 to grow; that community-based resources are not integrated
10 into a centralized system for referrals, assessment of needs,
11 development of care plans, and case management; and that
12 persons in need of long-term care services have difficulty
13 accessing and using the current system, which is fragmented
14 and which results in inappropriate placements.

15 (2) The general assembly further finds, determines, and
16 declares that the state is in need of a long-term care system
17 that organizes each long-term care client's entry, assessment
18 of need, and service delivery into a single unified system;
19 and that such system must include, at a minimum, a locally
20 established single entry point administered by a designated
21 entity, a single client assessment instrument and
22 administrative process, targeted case management in order to
23 maximize existing federal, state, and local funding, case
24 management, and an accountability mechanism designed to assure
25 that budget allocations are being effectively managed.

26 (3) The general assembly therefore concludes that it is
27 appropriate to develop and implement a comprehensive and

1 uniform long-term care client assessment process and to study
2 the establishment of a single entry point system that provides
3 for the coordination of access and service delivery to
4 long-term care clients at the local level, that is available
5 to all persons in need of long-term care, and that is
6 well-managed and cost-efficient.
7 26-4.5-402. Definitions. As used in this part 4, unless
8 the context otherwise requires:
9 (1) "Activities of daily living" means the basic
10 self-care activities, including eating, bathing, dressing,
11 transferring from bed to chair, bowel and bladder control, and
12 independent ambulation.
13 (2) "Case management services" means the assessment of a
14 long-term care client's needs, the development and
15 implementation of a care plan for such client, the
16 coordination and monitoring of long-term care service
17 delivery, the evaluation of service effectiveness, and the
18 reassessment of such client's needs, all of which may be
19 performed by a single entry point as defined in subsection
20 (11) of this section or a designated case management agency as
21 defined in section 26-4.5-103 (2).
22 (3) "Community-based" has the same meaning as that set
23 forth in section 26-4.6-102 (2).
24 (4) "Comprehensive and uniform client assessment
25 process" means a standard procedure, which includes the use of
26 a uniform assessment instrument, to measure a client's
27 functional capacity, to determine the social and medical needs

1 of a current or potential client of any long-term care
2 program, and to target resources to the functionally
3 impaired.
4 (5) "Continuum of care" has the same meaning as that set
5 forth in section 26-4.6-102 (3).
6 (6) "Information and referral" means the provision of
7 specific, accurate, and timely public information about
8 services available to aging and disabled adults in need of
9 long-term care and referral to alternative agencies, programs,
10 and services based on client inquiries.
11 (7) "Instrumental activities of daily living" means home
12 management and independent living activities such as cooking,
13 cleaning, using a telephone, shopping, doing laundry,
14 providing transportation, and managing money.
15 (8) "Long-term care" has the same meaning as that set
16 forth in section 26-4.6-102 (7).
17 (9) "Resource development" means the study,
18 establishment, and implementation of additional resources or
19 services which will extend the capabilities of community
20 long-term care systems to better serve long-term care clients.
21 (10) "Screening" means a preliminary determination of
22 need for long-term care services and, on the basis of such
23 determination, the making of an appropriate referral for a
24 client assessment in accordance with section 26-4.5-403 or
25 referral to another community resource to assist clients who
26 are not in need of long-term care services.
27 (11) "Single entry point" means the availability of a

single access or entry point within a local area where a current or potential long-term care client can obtain long-term care information, screening, assessment of need, and referral to appropriate long-term care program and case management services.

(12) "Targeted case management" means case management, as defined in subsection (2) of this section, which is aimed at a specific group of clients receiving services under certain publicly funded programs and which is a federally reimbursable medicaid service in accordance with the federal Social Security Act, 42 U.S.C.A. Sec. 1396n (g) (1) and (2).

26-4.5-403. Comprehensive and uniform client assessment process - instrument. (1) On or before July 1, 1991, the state department shall establish, by rule and regulation in accordance with article 4 of title 24, C.R.S., a comprehensive and uniform client assessment process for all individuals in need of long-term care, the purpose of which is to determine the appropriate services and levels of care necessary to meet clients' needs, to analyze alternative forms of care and the payment sources for such care, and to assist in the selection of long-term care programs and services that meet clients' needs most cost-efficiently.

(2) Participation in the process shall be mandatory for clients of publicly funded long-term care programs, including, but not limited to, the following:

(a) Nursing homes;

(b) Home and community-based services for the elderly, the blind, and the disabled;

(c) Alternative care facilities;

(d) Home care allowance;

(e) Adult foster care;

(f) In-home services under the federal "Older Americans Act of 1965", as amended, 42 U.S.C. sec. 3001;

(g) Home health services for long-term care clients;

(h) Home and community-based services for persons living with acquired immune deficiency syndrome (AIDS).

(3) Private paying clients of long-term care programs may participate in the process for a fee to be established by the state department and adopted through rules and regulations.

(4) The state department, through rules and regulations, shall develop and implement no later than July 1, 1991, a uniform long-term care client needs assessment instrument for all individuals needing long-term care. The instrument shall be used as part of the comprehensive and uniform client assessment process to be established in accordance with subsection (1) of this section and shall serve the following functions:

(a) To obtain information on each client's status in the following areas:

(I) Activities of daily living and instrumental activities of daily living;

(II) Physical health;

(III) Cognitive and emotional well-being;

1 (IV) Social interaction and current support resources.
2 (b) To assess each client's physical environment in
3 terms of meeting the client's needs;
4 (c) To obtain information on each client's payment
5 sources, including obtaining financial eligibility information
6 for publicly funded long-term care programs;
7 (d) To disclose the need for more intensive needs
8 assessments in areas such as nutrition, adult protection,
9 dimentia, and mental health;
10 (e) To prioritize a client's need for care using
11 criteria established by the state department for specific
12 publicly funded long-term care programs;
13 (f) To serve as the functional assessment for the
14 determinations of medical necessity.
15 (5) On and after July 1, 1991, no publicly funded client
16 shall be placed in a long-term care program unless such
17 placement is in accordance with rules and regulations adopted
18 by the state department in implementing this section.
19 26-4.5-404. Long-term care access system study - report
20 - implementation. (1) On or before October 1, 1990, the
21 state department shall develop and conduct a study of the
22 development and implementation of a centralized long-term care
23 access system which provides for the coordination of long-term
24 care services at the community level and which is available to
25 all persons in need of long-term care services.
26 (2) The study shall include recommendations concerning
27 the following components of such a system:

1 (a) The use of a single entry point agency responsible
2 for administering the local single entry point system;
3 (b) The use of contracts between the state department
4 and the single entry point agency for reimbursement for
5 services performed in accordance with performance standards
6 adopted by the state department;
7 (c) The role of the single entry point using the
8 comprehensive and uniform client assessment process
9 established in accordance with section 26-4.5-403 and case
10 management;
11 (d) The use of an accountability mechanism for assuring
12 that budget allocations are being efficiently managed;
13 (e) Costs and budget impacts for implementing and
14 operating a single entry point system;
15 (f) A plan for selecting such single entry point agency
16 including the process of selection and selection criteria;
17 (g) The long-term care services and programs to be
18 assessed through the single entry point system;
19 (h) Data system modifications required;
20 (i) A proposed timetable for implementation;
21 (j) Legislative and federal waiver changes needed;
22 (k) Services to private pay clients;
23 (l) Financial eligibility applications and
24 determination;
25 (m) The feasibility and cost-effectiveness of
26 establishing a statewide single entry point system;
27 (n) The system's relationship to long-term care

1 programs.

2 (3) The executive director shall evaluate the overall
3 effectiveness of the system and shall submit written findings
4 and recommendations concerning the establishment and operation
5 of a statewide single entry point system to the general
6 assembly no later than October 1, 1990.

7 SECTION 2. <u>Safety clause</u>. The general assembly hereby
8 finds, determines, and declares that this act is necessary
9 for the immediate preservation of the public peace, health,
10 and safety.

BILL 2

A BILL FOR AN ACT

CONCERNING THE ENACTMENT OF A STATE LONG-TERM CARE OMBUDSMAN ACT IN COMPLIANCE WITH THE FEDERAL "OLDER AMERICANS ACT OF 1965", AS AMENDED.

Bill Summary

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

Enacts the "Colorado Long-term Care Ombudsman Act" in conformance with the federal "Older Americans Act of 1965", as amended. Provides for the establishment of a statewide long-term care ombudsman program which consists of a state office that is administered by a state long-term care ombudsman and local offices designated by the state long-term care ombudsman as representatives of the state office. Makes the state long-term care ombudsman responsible for implementing a program designed to assist residents of long-term care facilities in asserting their civil, human, and legal rights. Defines additional duties of the state ombudsman. Clarifies that personnel of local ombudsman offices are representatives of the state office. Provides for ombudsman access to long-term care facilities, residents, and records in order to serve residents. Provides civil and criminal immunity for ombudsmen who act in good faith. Imposes sanctions against persons who interfere with any ombudsman performing ombudsman duties or who retaliate against specified individuals who communicate with an ombudsman performing ombudsman duties. Defines duties of the state department of social services.

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

SECTION 1. Title 26, Colorado Revised Statutes, 1989 Repl. Vol., is amended BY THE ADDITION OF A NEW ARTICLE to read:

ARTICLE 11.5

Colorado Long-term Care Ombudsman Program

26-11.5-101. Short title. This article shall be known and may be cited as the "Colorado Long-term Care Ombudsman Act".

26-11.5-102. Legislative declaration. (1) The general assembly hereby recognizes that the state department of social services, pursuant to the federal "Older Americans Act of 1965", as amended, has established a state long-term care ombudsman program.

(2) The general assembly finds, determines, and declares that it is the public policy of this state to encourage community contact and involvement with patients, residents, and clients of long-term care facilities.

(3) The general assembly further finds, determines, and declares that in order to comply with the federal "Older Americans Act of 1965", as amended, and effectively assist patients, residents, and clients of long-term care facilities in the assertion of their civil, human, and legal rights, the structure of a state long-term care ombudsman program and the powers and duties thereunder shall be specifically defined.

26-11.5-103. Definitions. As used in this article, unless the context otherwise requires:

(1) "Elderly resident" means any individual who is sixty years of age who is a current or prospective or former patient or client of any long-term care facility.

(2) "Local ombudsman" means an individual trained and designated as qualified by the state long-term care ombudsman to act as a representative of the office of the state long-term care ombudsman.

(3) "Long-term care facility" or "facility" means:

(a) A nursing care facility as defined in section 26-4-103 (6.5);

(b) A personal care boarding home as defined in section 25-27-102 (8), C.R.S.;

(c) Any swing bed in an acute care facility or extended care facility.

(4) "Office" means the state long-term care ombudsman office.

(5) "Older Americans act" means the federal "Older Americans Act of 1965", as amended, 42 U.S.C. sec. 3001.

(6) "Resident" means any individual who is a current or prospective or former patient or client of any long-term care facility.

(7) "State long-term care ombudsman" means the person designated to implement the state long-term care ombudsman program and to perform the duties and functions required under this article.

26-11.5-104. <u>Creation of state long-term care ombudsman program</u>. (1) Pursuant to the older Americans act, there is

hereby established a state long-term care ombudsman program which shall be comprised of a state long-term care ombudsman office and local ombudsman offices established throughout the state.

(2) The state long-term care ombudsman office shall be established and operated under the state department of social services either directly or by contract with or grant to any public agency or other appropriate private nonprofit organization; except that such office shall not be administered by any agency or organization responsible for licensing or certifying long-term care services in the state. The office shall be administered by a full-time qualified state long-term care ombudsman who shall be designated in accordance with rules and regulations promulgated by the state department.

(3) Local ombudsman programs shall be established statewide. Such programs shall be operated by the state department under contract, grant, or agreement between the state department and a public agency or an appropriate private nonprofit organization. Personnel of local programs shall be trained and designated as qualified representatives of the office in accordance with section 26-11.5-105 (1) (b).

26-11.5-105. <u>Duties of state long-term care ombudsman</u>. (1) In addition to such other duties and functions as the state department may allocate to the office, the state long-term care ombudsman shall have the following duties and functions in implementing a statewide long-term care ombudsman

program:

(a) (I) Establish statewide policies and procedures for operating the state long-term care ombudsman program including procedures to identify, investigate, and seek the resolution or referral of complaints made by or on behalf of any elderly resident related to any action, inaction, or decision of any provider of long-term care services or of any public agency, including the state and county departments of social services, that may adversely affect the health, safety, welfare, or rights of such elderly resident.

(II) The policies and procedures adopted pursuant to subparagraph (I) of this paragraph (a) may be applied to complaints by or on behalf of any resident of a long-term care facility where the provision of ombudsman services will either benefit elderly residents of the facility involved in the complaint or elderly residents of long-term care facilities in general, or where ombudsman service is the only viable avenue of assistance available to the resident and such service will not significantly diminish the program's effort on behalf of elderly residents.

(b) Provide training and technical assistance to personnel of local ombudsman programs. Upon successful completion of such training the office may designate such personnel as qualified representatives of the office and shall issue to such representatives long-term care ombudsman identification cards.

(c) Establish procedures to analyze and monitor the

development and implementation of federal, state, and local laws, regulations, and policies with respect to long-term care facilities and services. On the basis of such analysis and monitoring, the office shall recommend changes to such laws, regulations, and policies to the appropriate governing body.

(d) Prepare a notice informing residents of ombudsman services for posting at long-term care facilities.

(2) In addition to the duties and functions under subsection (1) of this section, the office and its representatives shall have the authority to pursue administrative, legal, or other appropriate remedies on behalf of residents for the purpose of effectively carrying out the provisions of paragraph (a) of subsection (1) of this section.

26-11.5-106. <u>Local ombudsmen - representatives of office</u>. (1) A local ombudsman, whether an employee or volunteer of a local ombudsman program, shall be considered a representative of the office for the purposes of carrying out policies and procedures adopted by the state long-term care ombudsman in accordance with this article, but only upon the completion of training and designation as a qualified representative by the state long-term care ombudsman. As a representative of the office, a local ombudsman shall follow rules and regulations of the state department and policies and procedures established by the state long-term care ombudsman.

(2) Each local ombudsman shall carry an identification card issued annually and signed by the state long-term care ombudsman and shall, upon the request of a supervisory staff

member of a facility, present such card in order to obtain access to residents and records of such facility.

26-11.5-107. Notice of ombudsman services. (1) Every long-term care facility shall post in a conspicuous place a notice with the name, address, and phone number of the office and the name, address, and phone number of the nearest available local ombudsman program. Such notice shall be provided by the state long-term care ombudsman.

(2) Each long-term care facility shall provide, in writing, to any resident eligible for ombudsman services pursuant to this article who is subject to an involuntary transfer from such facility the name, address, and phone number of the nearest available local ombudsman and the name, address, and phone number of the office. Such information shall be included on the notice required under section 25-1-120 (1) (k), C.R.S.

26-11.5-108. Access to facility - residents - records - confidentiality. (1) An ombudsman, upon presenting a long-term care ombudsman identification card, shall have immediate access to a long-term care facility and to its residents eligible for ombudsman services pursuant to this article for the purposes of effectively carrying out the provisions of this article.

(2) In performing ombudsman duties and functions in accordance with this article an ombudsman shall have access to review the medical and social records of a resident eligible for ombudsman services pursuant to this article, provided the

resident has consented to such review. In the event consent to such review is not available because the resident is incapable of consenting and has no guardian to provide such consent, inspection of such records may be made by the state long-term care ombudsman.

(3) In carrying out the provisions of this section, each ombudsman shall follow procedures of confidentiality in accordance with the older Americans act.

26-11.5-109. Interference with ombudsmen prohibited - civil penalty. (1) No person shall willfully interfere with an ombudsman in the ombudsman's performance of duties and functions under this article.

(2) No person shall take any discriminatory, disciplinary, or retaliatory action against the following individuals for any communication with an ombudsman or for any information provided in good faith to the office in carrying out its duties and responsibilities under this article:

(a) Any resident eligible for ombudsman services pursuant to this article;

(b) Any officer or employee of a facility or governmental agency providing services to residents of long-term care facilities.

(3) (a) Any person who commits a violation under subsection (1) or (2) of this section shall be subject to the following civil penalties:

(I) For a violation of subsection (1) of this section, a penalty of not more than two thousand five hundred dollars per

1 violation;

2 (II) For a violation of subsection (2) of this section,
3 a penalty of not more than five thousand dollars per
4 violation.

5 (b) All penalties shall be determined and collected by
6 the district court of the county in which the violation
7 occurred. All penalties collected pursuant to this section
8 shall be transmitted to the state treasurer, who shall credit
9 the same to the general fund. Penalties provided under this
10 section shall be in addition to and not in lieu of any other
11 remedy provided by law.

12 26-11.5-110. Immunity from liability. Any ombudsman
13 who, in good faith, acts within the scope of the duties and
14 functions of this article shall be immune from civil or
15 criminal liability. For the purposes of this section, there
16 shall be a rebuttable presumption that, when acting within the
17 scope of the duties and functions of this article, an
18 ombudsman acts in good faith.

19 26-11.5-111. Duties of state department. (1) In order
20 to implement the provisions of this article, the state
21 department shall carry out the following duties:

22 (a) Establish a statewide uniform reporting system to
23 collect and analyze data relating to complaints and conditions
24 in long-term care facilities for the purpose of identifying
25 and resolving significant problems, with specific provision
26 for the submission of such data on a regular basis to the
27 state agency responsible for licensing or certifying long-term

1 care facilities;

2 (b) Establish procedures to assure that information
3 contained in any files maintained in accordance with the state
4 long-term care ombudsman program shall be disclosed only at
5 the discretion of the state long-term care ombudsman and that
6 the identity of a complainant be disclosed only with the
7 written consent of such complainant or in accordance with a
8 court order;

9 (c) Ensure that no individual involved in the
10 designation of the state long-term care ombudsman, nor any
11 officer, employee, or volunteer of the statewide program in
12 performing ombudsman functions, is subject to any conflict of
13 interest;

14 (d) Ensure that adequate legal counsel is available to
15 an ombudsman for advice and counseling concerning the
16 performance of ombudsman duties and functions and for legal
17 representation of an ombudsman against whom legal action is
18 brought in connection with the performance of ombudsman duties
19 and functions provided for under this article;

20 (e) Promulgate rules and regulations necessary for the
21 efficient administration and operation of the state long-term
22 care ombudsman program.

23 26-11.5-112. Federal requirements - compliance. Nothing
24 in this article shall be construed to prevent the state
25 department or the office from complying with the requirements
26 of the rules and regulations of the United States department
27 of health and human services promulgated pursuant to the older

1 Americans act.

2 SECTION 2. No appropriation. The general assembly has
3 determined that this act can be implemented within existing
4 appropriations, and therefore no separate appropriation of
5 state moneys is necessary to carry out the purposes of this
6 act.

7 SECTION 3. Safety clause. The general assembly hereby
8 finds, determines, and declares that this act is necessary
9 for the immediate preservation of the public peace, health,
10 and safety.

BILL 3

A BILL FOR AN ACT

1 CONCERNING PAYMENT TO VENDORS WHO PROVIDE LONG-TERM CARE
2 SERVICES UNDER THE "COLORADO MEDICAL ASSISTANCE ACT", AND
3 MAKING AN APPROPRIATION IN CONNECTION THEREWITH.

Bill Summary

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

Authorizes the department of social services to increase payments to nursing home vendors under the "Colorado Medical Assistance Act" to allow such vendors to cover newly incurred costs related to the requirements under the federal "Omnibus Budget Reconciliation Act of 1987", as amended, P.L. 100-203.

Requires the state department of social services to design and conduct a pilot project, centered around twenty nursing facilities around the state, to study the cost-efficiency of implementing a statewide case mix reimbursement system as an alternative method for reimbursing certain nursing home vendors for health care services rendered under the "Colorado Medical Assistance Act". Allows the state department to make case mix reimbursements to facilities that participate in the project. Specifies system components to be developed and evaluated under the project. Creates an advisory committee to assist the state department in designing the project, developing rules and regulations, and evaluating the project. Requires a report to the general assembly, with recommendations concerning statewide implementation of a case mix reimbursement system. Allows facilities involved in the project to continue participation in the system on a voluntary basis if the state department recommends statewide implementation, but only for a specified period.

Establishes a quality of care incentive allowance to be distributed to approved long-term health care facilities which are in compliance with conditions and standards in the annual initial medicaid recertification survey. Creates an advisory committee to establish criteria, review applications, and award the incentive allowance. Outlines the factors to be considered by the advisory committee in awarding the incentive allowance. Directs the state department of social services to verify that the award was used for its intended purpose. Provides that such awards shall not be offset against related costs when such costs are used for ongoing expenditures.

Makes appropriations.

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1 Be it enacted by the General Assembly of the State of Colorado:
2 SECTION 1. 26-4-110 (5), Colorado Revised Statutes, 1989
3 Repl. Vol., is amended BY THE ADDITION OF A NEW PARAGRAPH to
4 read:
5 26-4-110. Vendors - payments - rules.
6 (5) (a.5) (I) For the purpose of making payments to nursing
7 home vendors for services rendered on and after July 1, 1990,
8 through June 30, 1991, the state department shall establish
9 rates which include a pass-through adjustment to vendor
10 payment rates which are based on estimates developed by the
11 state department, and which are sufficient to cover
12 eighty-five percent of the cost vendors are reasonably
13 expected to incur to comply with the increased quality of care
14 standards mandated by the federal "Omnibus Budget
15 Reconciliation Act of 1987", as amended, P.L. 100-203, and not
16 otherwise previously mandated by federal and state rules,
17 regulations, or statutes. The pass-through payment is limited
18 to class I, II, IV, and V nursing home vendors, as defined by
19 the state board in rules and regulations, with rates
20 established on a prospective basis. These payments shall not

1 exceed ______dollars in fiscal year 1990 and ______ dollars
2 in fiscal year 1991.
3 (II) The state board shall adopt rules and regulations
4 which assure that pass-through payments are made in accordance
5 with the following provisions:
6 (A) Vendors' requests shall provide financial and other
7 documentation on forms required by the state board which
8 adequately support the pass-through payment.
9 (B) Pass-through payments shall be based on the minimum
10 costs a nursing home can reasonably be expected to incur and
11 shall cover only those costs which represent new cost levels
12 not previously incurred by the vendor for similar costs
13 activity and which represent costs over and above the
14 previously incurred level of costs by the vendor. The costs
15 described in subparagraph (I) of this paragraph (a.5) incurred
16 on a one-time basis and paid for by the pass-through shall not
17 be used in setting future prospective rates. All pass-through
18 payments shall be subject to audit and adjustment and subject
19 to the provisions specified in this article.
20 (III) A vendor who has been overpaid through the
21 pass-through of payments, as determined through the audit
22 process, shall repay the state in accordance with section
23 26-4-112. The vendor may appeal the determination of an
24 overpayment in accordance with article 4 of title 24, C.R.S.;
25 except that the vendor shall not have the right to a stay
26 pending appeal of the repayment of the pass-through to the
27 state.

1 (IV) When audit results show that a vendor has been
2 underpaid through the pass-through of payments, the state
3 department shall pay the appropriate amount of reimbursement
4 to the vendor within ninety days.
5 (V) The limitations on reasonable costs of services
6 provided in section 26-4-103 (4.5) shall not apply to the
7 pass-through payments and rate adjustments provided for in
8 this paragraph (a.5).
9 (VI) The provisions of this paragraph (a.5) shall expire
10 with rate of payments on or after October 1, 1991.
11 SECTION 2. Article 4 of title 26, Colorado Revised
12 Statutes, 1989 Repl. Vol., is amended BY THE ADDITION OF THE
13 FOLLOWING NEW SECTIONS to read:
14 26-4-110.3. Alternative reimbursement - nursing homes -
15 pilot project. (1) In recognition of the need to encourage
16 the well-planned development of a fair and equitable
17 reimbursement system for nursing home vendors, linking
18 reimbursement payments to a resident classification system
19 that reflects the level of health care needed by different
20 classes of residents and thereby improving the quality of care
21 in nursing homes by targeting reimbursement dollars where
22 patient needs are the greatest, the general assembly hereby
23 finds, determines, and declares that it is necessary and
24 appropriate for the state department to conduct a pilot
25 project to study the use of a case mix reimbursement system as
26 an alternative methodology for setting reimbursement rates for
27 health care services provided by nursing home vendors in the

state.

(2) As used in this section, unless the context otherwise requires:

(a) "Case mix reimbursement system" means a comprehensive claims processing system for reimbursing nursing facilities as defined in paragraph (b) of this subsection (2), which reimbursement is based on resident case mix and related resident resource consumption.

(b) "Nursing facility" means any "intermediate nursing facility" as defined in section 26-4-103 (3.4) (a) and any "skilled nursing facility" as defined in section 26-4-103 (6.5).

(c) "OBRA" means the federal "Omnibus Budget Reconciliation Act of 1987" (P.L. 100-203).

(3) (a) On or before July 1, 1992, the state department shall develop and conduct a pilot project to study the statewide use of a case mix reimbursement system. In designing the pilot project the state department shall consider the recommendations made by the university of Colorado health sciences center in a report issued in June, 1989, entitled "Colorado Nursing Home Case Mix Reimbursement Project - Recommended Nursing Home Case Mix Reimbursement System for the Colorado Medicaid Program".

(b) In conducting the pilot project the state department may make case mix reimbursement payments to no more than twenty nursing facilities that shall be selected by the state department. Facilities with large mental health populations

shall be represented in facilities selected for the pilot project. Reimbursement payments made pursuant to this section shall cover only health care costs and costs associated with compliance with OBRA incurred by nursing facilities. All other reimbursement payments for items such as administration, room and board, and property costs shall be made in accordance with section 26-4-110 (5).

(c) The pilot project shall include at a minimum the development and an evaluation of the following components:

(I) An administrative procedure for assessing the care needs of nursing home residents through the use of developed assessment instruments designed to identify special needs. Such instruments, if feasible, shall incorporate the resident assessment instrument required under OBRA. An assessment shall serve as the basis for the amount and type of case mix payments.

(II) An audit process to assure that initial assessments are correct and that quality of care results are achieved;

(III) A payment procedure that ensures timely and accurate case mix payments to nursing home vendors, which may include altering or redesigning the current claims processing system used by the state department;

(IV) Training for nursing care facility staff in the use of resident case mix assessment instruments and claims processing procedures;

(V) A reliable method of measuring the fiscal impact of case mix reimbursement on state expenditures for any medical

services rendered in accordance with this article to persons in need of long-term care, including any impact on hospital utilization by such persons;

(VI) A reliable method for monitoring the impact of case mix reimbursement on facility operations, including a facility's ability to provide quality care and satisfy requirements under OBRA;

(VII) The inclusion of costs related to expenses incurred by a facility in complying with requirements under OBRA, including training for nurse aides and conducting resident assessments;

(VIII) A quality incentive program under which a nursing facility shall be paid incentives for providing quality of care that exceeds standards adopted by the state department. Such incentives shall be paid out of funds otherwise required to be paid to the facility in accordance with section 26-4-110 (5) (c).

(4) There is established an advisory committee to the state department for the purpose of making recommendations to the state department concerning the design of the pilot project and the development of rules and regulations and to assist the state department in evaluating the pilot project. The advisory committee shall consist of not less than nine members to be appointed by the executive director. The committee shall elect its own chairperson. Such members shall include representatives from the Colorado health care association, the Colorado association of homes for the aging,

the long-term care ombudsman, the state department, the department of health, the department of institutions, and other organizations involved with consumer issues related to long-term care. Members of the advisory committee shall serve without compensation.

(5) The executive director, with the assistance of the advisory committee, shall evaluate the overall effectiveness of the case mix reimbursement system and shall submit written findings and recommendations concerning the establishment and operation of a statewide case mix reimbursement system to the general assembly no later than July 1, 1992. The written findings and recommendations shall specifically address the administrative feasibility and cost-efficiency of the components of the pilot project.

(6) If the executive director recommends the implementation of a statewide case mix reimbursement system, the state department may continue to make reimbursement payments to any nursing facility selected for the pilot project that elects to continue participation in such a system until such time as the general assembly enacts legislation that provides for statewide implementation of the case mix reimbursement system or July 1, 1993, whichever occurs first.

(7) The state department shall promulgate rules and regulations necessary for the implementation of this section.

(8) This section is repealed, effective July 1, 1993.

26-4-110.4. Quality of care incentive allowance. (1) In order to encourage quality of care for long-term care

patients and to enhance patients' rights, involvement, and freedom of choice, there is hereby established a quality of care incentive allowance, subject to available appropriations, which shall be distributed by awards to those long-term health care facilities which meet certain eligibility criteria as set forth in this section and based on certain factors set forth in this section.

(2) There is hereby created a quality of care incentive advisory committee, referred to in this section as the "committee", to establish criteria on quality of life and quality of care issues, establish the application process and review applications for the incentive allowance, and award the quality of care incentive allowance as provided in this section. The committee shall consist of nine members, two of whom shall be representatives of senior citizen organizations, one each appointed by the speaker of the house of representatives and the president of the senate; one of whom shall be a member of the house of representatives, appointed by the speaker of the house of representatives; one of whom shall be a member of the senate, appointed by the president of the senate; one of whom shall be the state long-term care ombudsman; one of whom shall be a representative of the state department, appointed by the executive director of the state department; one of whom shall be a representative of the department of health, appointed by the executive director of the department of health; and two of whom shall represent nursing home associations, one each appointed by the speaker

of the house of representatives and the president of the senate. The representatives of the senior citizen organizations, the legislative members, and the state ombudsman shall be voting members of the committee and the remaining members shall be nonvoting members. No member of the committee shall receive compensation or a per diem allowance for his service on the committee. Appointed members of the committee shall serve for terms of three years.

(3) Only long-term health care facilities which have been found to be in compliance with all of the conditions or standards in the initial annual medicaid recertification survey conducted by the department of health shall be eligible to apply to the committee for a quality of care incentive allowance.

(4) Any long-term health care facility which is eligible under the requirements of subsection (3) of this section may apply to the committee for consideration to receive a quality of care incentive allowance. Such application shall include the information prescribed by the committee, including a statement of how the long-term health care facility intends to spend the allowance, if awarded, and how such plans for expenditure would improve the quality of care in the facility. The committee shall accept applications each year, and any long-term health care facility which is eligible may apply each year. The committee shall review all applications and determine which applicants shall receive a quality of care incentive allowance. In making such determination, the

committee shall consider the following factors:

(a) The intentions of the long-term health care facility in spending the allowance to further improve the quality of care in the facility;

(b) That greater priority shall be given to those facilities which have a higher proportion of medicaid patients than nonmedicaid patients.

(5) (a) Any moneys received by a long-term health care facility as a result of an incentive allowance awarded under this section shall not be offset against related costs when such costs are used for ongoing expenditures.

(b) The state department shall ensure that the long-term health care facility uses the funds for which an incentive allowance is granted pursuant to this section for its intended purpose.

(6) Any award of a quality of care incentive allowance shall be a grant which is awarded to the long-term health care facility at the beginning of a fiscal year and shall be calculated by using a daily rate per patient based on the medicaid census of patients in the particular long-term health care facility.

(7) The department of health shall provide the necessary survey information to the state department and the committee.

SECTION 3. Appropriation. (1) In addition to any other appropriation, there is hereby appropriated, to the department of social services, for the fiscal year beginning July 1, 1990:

(a) The sum of ________ dollars ($), or so much thereof as may be necessary, for the implementation of section 1 of this act. Of said sum, ________ dollars ($) shall be from the general fund, and ________ dollars ($) shall be from federal funds.

(b) The sum of ________ dollars ($), or so much thereof as may be necessary, for the implementation of section 26-4-110.3, Colorado Revised Statutes, as contained in section 2 of this act. Of said sum, ________ dollars ($) shall be from the general fund, and ________ dollars ($) shall be from federal funds.

(c) The sum of ________ dollars ($), or so much thereof as may be necessary, for the implementation of section 26-4-110.4, Colorado Revised Statutes, as contained in section 2 of this act. Of said sum, ________ dollars ($) shall be from the general fund, and ________ dollars ($) shall be from federal funds.

SECTION 4. Effective date. This act shall take effect July 1, 1990.

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

BILL 4

A BILL FOR AN ACT

1 CONCERNING THE REPLICATION OF A COMPREHENSIVE LONG-TERM CARE
2 CAPITATION MODEL PROGRAM OF ALL-INCLUSIVE CARE FOR THE
3 ELDERLY.

Bill Summary

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

Directs the state department of social services to evaluate the appropriateness of applying for medicaid waivers from the federal government in order to participate in a national replication project to implement a program of all-inclusive care for the elderly, known as the PACE program. Authorizes the state department of social services to apply for waivers upon a finding of appropriateness, and to negotiate a contract with a nonprofit community-based organization for a pilot project to provide comprehensive health care services on a capitated basis to frail elderly persons who are at risk of nursing home placement. Uses a risk-based financing model whereby the nonprofit organization receives a capitated monthly amount from medicare and medicaid for each eligible participant in the program and uses such funds to manage the service needs of the participant as determined by a multidisciplinary team assigned for that participant. Sets forth the requirements of the PACE program.

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4 Be it enacted by the General Assembly of the State of Colorado:
5 SECTION 1. Title 26, Colorado Revised Statutes, 1989

1 Repl. Vol., is amended BY THE ADDITION OF A NEW ARTICLE to
2 read:
3 ARTICLE 16
4 Program of All-Inclusive Care for the Elderly
5 26-16-101. Short title. This article shall be known and
6 may be cited as the "Program of All-Inclusive Care for the
7 Elderly Act", and the program established by this article is
8 referred to in this article as the "PACE program".
9 26-16-102. Legislative declaration. (1) The general
10 assembly hereby finds and declares that it is the intent of
11 this article to replicate the ON LOK program in San Francisco,
12 California, that has proven to be cost-effective at both the
13 state and federal levels. The PACE program is part of a
14 national replication project authorized in section 9412(b)(2)
15 of the federal "Omnibus Reconciliation Act of 1986", as
16 amended, which instructs the secretary of the federal
17 department of health and human services to grant medicare and
18 medicaid waivers to permit not more than ten public or
19 nonprofit private community-based organizations in the country
20 to provide comprehensive health care services on a capitated
21 basis to frail elderly who are at risk of
22 institutionalization. The general assembly finds that by
23 coordinating an extensive array of medical and nonmedical
24 services, the needs of the participants will be met primarily
25 in an outpatient environment in an adult day health center, in
26 their homes, or in an institutional setting. The general
27 assembly finds that such a service delivery system will

enhance the quality of life for the participant, and offers the potential to reduce and cap the costs to Colorado of the medical needs of the participants, including hospital and nursing home admissions.

(2) The general assembly declares that the purpose of this article is to provide services which would foster the following goals:

(a) To maintain eligible persons at home as an alternative to long-term institutionalization;

(b) To provide optimum accessibility to various important social and health resources that are available to assist eligible persons in maintaining independent living;

(c) To provide that eligible persons who are frail elderly but who have the capacity to remain in an independent living situation have access to the appropriate social and health services without which independent living would not be possible;

(d) To coordinate, integrate, and link such social and health services by removing obstacles which impede or limit improvements in delivery of these services;

(e) To provide the most efficient and effective use of capitated funds in the delivery of such social and health services;

(f) To assure that capitation payments amount to no more than ninety-five percent of the amount paid under the medicaid fee-for-service structure for an actuarially similar population.

26-16-103. Services for eligible persons. (1) Within the context of the PACE program, the state department may include any or all of the services listed in article 4 or 4.5 of this title.

(2) An eligible person may elect to receive services from the PACE program as described in subsection (1) of this section. If such an election is made, the eligible person shall not remain eligible for services or payment through the regular medicare or medicaid programs. All services provided by said programs shall be provided through the PACE program in accordance with this article. An eligible person may elect to disenroll from the PACE program at any time.

(3) For purposes of this section, "eligible person" means a frail elderly individual who voluntarily enrolls in the PACE program and whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, whose resources do not exceed the limit established by the state department for individuals receiving a mandatory minimum state supplementation of SSI benefits pursuant to section 26-2-204, and for whom a physician licensed pursuant to article 36 of title 12, C.R.S., certifies that such a program provides an appropriate alternative to institutionalized care. The term "frail elderly" means an individual who meets functional eligibility requirements, as established by the state department, for nursing home care and who is sixty-five years of age or older.

(4) Using a risk-based financing model, the nonprofit

organization providing the PACE program shall assume responsibility for all costs generated by PACE program participants, and it shall create and maintain a risk reserve fund that will cover any cost overages for any participant. The PACE program is responsible for the entire range of services in the consolidated service model, including hospital and nursing home care, according to participant need as determined by the multidisciplinary team. The nonprofit organization providing the PACE program is responsible for the full financial risk at the conclusion of the demonstration period and when permanent waivers from the federal health care financing administration are granted. Specific arrangements of the risk-based financing model shall be adopted and negotiated by the federal health care financing administration, the nonprofit organization providing the PACE program, and the state department.

26-16-104. Program established - financial eligibility. (1) Upon receipt of federal waivers, the state department shall implement the PACE program as a demonstration program to provide the services set forth in section 26-16-103 (1) to eligible persons, as defined in section 26-16-103 (3). The demonstration program shall be implemented to provide services to eligible persons beginning on or after July 1, 1991, and shall continue until permanent waivers are granted from the federal health care financing administration, but no later than July 1, 1995. During the 1995 legislative session, the general assembly shall reexamine the PACE program and, acting

by bill, determine if the program should be implemented on a permanent basis.

(2) Any person who accepts and receives services authorized under this article shall pay to the state department or to an agent or vendor designated by the state department an amount which shall be the lesser of such person's gross income minus the current federal aid to needy disabled supplemental security income benefit level and cost of dependents and minus any amounts paid for private health or medical insurance, or the projected cost of services to be rendered to the person under the plan of care. Such amount shall be reviewed and revised as necessary each time the plan of care is reviewed. The state department shall establish a standard amount to be allowed for the costs of dependents. In determining a person's gross income, the state department shall establish, by rule, a deduction schedule to be allowed and applied in the case of any person who has incurred excessive medical expenses or other outstanding liabilities which require payments.

26-16-105. Duties of the state department. (1) The state department of social services shall apply in a joint application with the nonprofit organization providing the PACE program to the federal health care financing administration for those medicaid and medicare waivers necessary to implement the PACE program set forth in this article. Application for the waivers shall be made only if the state department determines from the evaluation specified in subsection (2) of

this section that the PACE program is cost-effective.

(2) The state department shall contract with an agency with health services evaluation experience for evaluations of the PACE program, including whether the program is cost-effective. The state department shall present to the general assembly reports based on such evaluations prior to submitting the joint application for waivers on or before November 1, 1994.

(3) The state department shall provide a system for reimbursement for services to the PACE program pursuant to this article.

(4) The state department shall develop and implement a contract with the nonprofit organization providing the PACE program which sets forth contractual obligations for the PACE program including but not limited to reporting and monitoring of utilization of costs of the program as required by the state department.

(5) The state department acknowledges that it is participating in the national PACE project as initiated by congress.

(6) The state department shall be responsible for certifying the eligibility for services of all PACE program participants.

26-16-106. Rules and regulations. The state board of social services shall promulgate such rules and regulations, pursuant to article 4 of title 24, C.R.S., as are necessary to implement this article.

26-16-107. Rate of payment - appropriations. The general assembly shall make appropriations to the state department of social services to fund services under this article provided at a monthly capitated rate. The state department of social services shall annually renegotiate a monthly capitated rate for the contracted services based on the ninety-five percent of the medicaid fee-for-service costs of an actuarially similar population.

26-16-108. Repeal. Unless extended by the general assembly, this article shall be repealed effective July 1, 1995.

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

BILL 5

A BILL FOR AN ACT

1 CONCERNING LONG-TERM CARE INSURANCE.

Bill Summary

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

Enacts the "Long-term Care Insurance Act", approved by the national association of insurance commissioners. Sets forth standards for long-term care insurance policies, including disclosure to consumers about the benefits and terms of such policies and requirements concerning preexisting conditions, hospitalization, and institutionalization. Provides that a policyholder has the right to return the policy and obtain a refund of the premium within a certain number of days after delivery of the policy. Details the elements of coverage in such policies. Repeals existing statutes governing long-term care policies.

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

3 SECTION 1. Article 19 of title 10, Colorado Revised
4 Statutes, 1987 Repl. Vol., as amended, is REPEALED AND
5 REENACTED, WITH AMENDMENTS, to read:

6 ARTICLE 19

7 Long-term Care Insurance

8 10-19-101. Short title. This article shall be known and

1 may be cited as the "Long-term Care Insurance Act".
2 10-19-102. Legislative declaration. The general
3 assembly hereby declares that the purpose of this article is
4 to promote the public interest and the availability of
5 long-term care insurance policies, to protect applicants for
6 long-term care insurance from unfair or deceptive sales or
7 enrollment practices, to establish standards for long-term
8 care insurance, to facilitate public understanding and
9 comparison of long-term care insurance policies, and to
10 facilitate flexibility and innovation in the development of
11 long-term care insurance coverage.
12 10-19-103. Definitions. As used in this article, unless
13 the context otherwise requires:
14 (1) "Applicant" means:
15 (a) In the case of an individual long-term care
16 insurance policy, the person who seeks to contract for
17 benefits; and
18 (b) In the case of a group long-term care insurance
19 policy, the proposed certificate holder.
20 (2) "Certificate" means any certificate issued under a
21 group long-term care insurance policy, which policy has been
22 delivered or issued for delivery in this state.
23 (3) "Commissioner" means the commissioner of insurance.
24 (4) "Group long-term care insurance" means a long-term
25 care insurance policy which is delivered or issued for
26 delivery in this state and issued to one of the following:
27 (a) One or more employers or labor organizations, or to

1 a trust or to the trustees of a fund established by one or
2 more employers or labor organizations, or a combination
3 thereof, for employees or former employees or a combination
4 thereof or for members or former members or a combination
5 thereof, of the labor organizations;
6 (b) Any professional, trade, or occupational association
7 for its members or former or retired members, or combination
8 thereof, if such association:
9 (I) Is composed of individuals all of whom are or were
10 actively engaged in the same profession, trade, or occupation;
11 and
12 (II) Has been maintained in good faith for purposes
13 other than obtaining insurance;
14 (c) (I) An association or a trust or the trustee of a
15 fund established, created, or maintained for the benefit of
16 members of one or more associations. Prior to advertising,
17 marketing, or offering such policy within this state, the
18 association or the insurer of the association shall file
19 evidence with the commissioner that the association has at the
20 outset a minimum of one hundred persons and has been organized
21 and maintained in good faith for purposes other than that of
22 obtaining insurance, has been in active existence for at least
23 one year, and has a constitution and bylaws which provide
24 that:
25 (A) The association holds regular meetings not less than
26 annually to further purposes of the members;
27 (B) Except for credit unions, the association collects

1 dues or solicits contributions from members; and
2 (C) The members have voting privileges and
3 representation on the governing board and committees.
4 (II) Thirty days after such filing, the association will
5 be deemed to satisfy such organizational requirements, unless
6 the commissioner makes a finding that the association does not
7 satisfy those organizational requirements.
8 (d) A group other than as described in paragraph (a),
9 (b), or (c) of this subsection (4), subject to a finding by
10 the commissioner that:
11 (I) The issuance of the group policy is not contrary to
12 the best interest of the public;
13 (II) The issuance of the group policy would result in
14 economies of acquisition or administration; and
15 (III) The benefits are reasonable in relation to the
16 premiums charged.
17 (5) "Long-term care insurance" means any insurance
18 policy or rider advertised, marketed, offered, or designed to
19 provide coverage for not less than twelve consecutive months
20 for each covered person on an expense-incurred, an indemnity,
21 a prepaid, or another basis for one or more necessary or
22 medically necessary diagnostic, preventive, therapeutic,
23 rehabilitative, maintenance, or personal care services,
24 provided in a setting other than an acute care unit of a
25 hospital. "Long-term care insurance" includes group and
26 individual policies or riders, whether issued by insurers,
27 fraternal benefit societies, nonprofit hospital,

medical-surgical, and health service corporations, prepaid health plans, health maintenance organizations, or any similar organization. "Long-term care insurance" shall not include any insurance policy which is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, catastrophic coverage, comprehensive coverage, accident-only coverage, specified disease or specified accident coverage, or limited-benefit health coverage.

(6) "Policy" means any policy, contract, subscriber agreement, rider, or endorsement delivered or issued for delivery in this state by an insurer, fraternal benefit society, nonprofit hospital, medical-surgical, or health service corporation, prepaid health plan, health maintenance organization, or any similar organization.

10-19-104. Scope and applicability of article. The requirements of this article shall apply to policies delivered or issued for delivery in this state on or after July 1, 1990. This article is not intended to supersede the obligations of entities subject to this article to comply with the substance of other applicable insurance laws insofar as they do not conflict with this article; except that laws and regulations designed and intended to apply to medicare supplement insurance policies shall not be applied to long-term care insurance. A policy which is not advertised, marketed, or

offered as long-term care insurance or nursing home insurance need not meet the requirements of this article.

10-19-105. Extraterritorial jurisdiction - group long-term care insurance. A group long-term care insurance coverage shall not be offered to a resident of this state under a group policy issued in another state to a group described in section 10-19-103 (4) (d), unless this state or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this state has made a determination that such requirements have been met.

10-19-106. Rules on disclosure. The commissioner may adopt rules and regulations that include standards for full and fair disclosure setting forth the manner, content, and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definitions of terms. Such rules and regulations shall be in accordance with the "State Administrative Procedure Act", article 4 of title 24, C.R.S.

10-19-107. Performance standards. (1) A long-term care insurance policy may not:

(a) Be cancelled, nonrenewed, or otherwise terminated on

1 the grounds of the age or the deterioration of the mental or
2 physical health of the insured individual or certificate
3 holder; or
4 (b) Contain a provision establishing a new waiting
5 period in the event that existing coverage is converted to or
6 replaced by a new or other form within the same company,
7 except with respect to an increase in benefits voluntarily
8 selected by the insured individual or group policyholder;
9 (c) Provide coverage for skilled nursing care only or
10 provide significantly more coverage for skilled care in a
11 facility than coverage for lower levels of care. This
12 evaluation of the amount of coverage provided shall be based
13 on aggregate days of care covered for lower levels of care,
14 when compared to days of care covered for skilled care; or
15 (d) Exclude coverage for Alzheimer's disease, senile
16 dementia, other organic brain syndromes, or other types of
17 senility diseases.
18 10-19-108. <u>Requirements for preexisting conditions</u>.
19 (1) A long-term care insurance policy or certificate, other
20 than a policy or certificate thereunder, issued to a group as
21 defined in section 10-19-103 (4) (a), (4) (b), or (4) (c),
22 shall not use a definition of "preexisting condition" which is
23 more restrictive than the following: "Preexisting condition"
24 means the existence of symptoms which would cause an
25 ordinarily prudent person to seek diagnosis, care, or
26 treatment or a condition for which medical advice or treatment
27 was recommended by or received from a provider of health care

1 services within six months preceding the effective date of
2 coverage of an insured person.
3 (2) A long-term care insurance policy or certificate,
4 other than a policy or certificate thereunder issued to a
5 group as defined in section 10-19-103 (4) (a), (4) (b), or (4)
6 (c), shall not exclude coverage for a loss or confinement
7 which is the result of a preexisting condition, unless such
8 loss or confinement begins within six months following the
9 effective date of coverage of an insured person.
10 (3) The commissioner may extend the limitation periods
11 set forth in subsections (1) and (2) of this section to
12 specific age group categories or specific policy forms upon
13 findings that the extension is in the best interest of the
14 public.
15 (4) The definition of "preexisting condition" in
16 subsection (1) of this section does not prohibit an insurer
17 from using an application form designed to elicit the complete
18 health history of an applicant and, on the basis of the
19 answers on the application, from underwriting in accordance
20 with that insurer's established underwriting standards.
21 Unless otherwise provided in the policy or certificate, a
22 preexisting condition, regardless of whether it is disclosed
23 on the application, need not be covered until the waiting
24 period described in subsection (2) of this section expires. A
25 long-term care insurance policy or certificate shall not
26 exclude or use waivers or riders of any kind to exclude,
27 limit, or reduce coverage or benefits for specifically named

1 or described preexisting diseases or physical conditions
2 beyond the waiting period described in subsection (2) of this
3 section, unless such waiver or rider has been specifically
4 approved by the commissioner.
5 10-19-109. Requirements for prior hospitalization or
6 institutionalization. (1) Effective July 1, 1991, a
7 long-term care insurance policy shall not be delivered or
8 issued for delivery in this state if such policy:
9 (a) Conditions the eligibility for any benefits on a
10 prior hospitalization requirement; or
11 (b) Conditions the eligibility for benefits provided in
12 an institutional care setting on the receipt of a higher level
13 of institutional care.
14 (2) (a) Effective July 1, 1991, a long-term care
15 insurance policy containing any limitations or conditions for
16 eligibility, other than those prohibited in subsection (1) of
17 this section shall clearly label in a separate paragraph of
18 the policy or certificate entitled "Limitations or Conditions
19 on Eligibility for Benefits" such limitations or conditions,
20 including any required number of days of confinement.
21 (b) A long-term care insurance policy containing a
22 benefit advertised, marketed, or offered as a home health care
23 or home care benefit shall not condition receipt of benefits
24 on a prior institutionalization requirement.
25 (c) A long-term care insurance policy which conditions
26 eligibility for noninstitutional benefits on the prior receipt
27 of institutional care shall not require a prior institutional

1 stay of more than thirty days for which benefits are paid.
2 (3) A long-term care insurance policy which provides
3 benefits only following institutionalization shall not
4 condition such benefits upon admission to a facility for the
5 same or related conditions within a period of less than thirty
6 days after discharge from the institution.
7 10-19-110. Loss ratio standards. The commissioner may
8 adopt rules and regulations establishing loss-ratio standards
9 for long-term care insurance policies if a specific reference
10 to long-term care insurance policies is contained in the
11 regulation. Such rules and regulations shall be in accordance
12 with the "State Administrative Procedure Act", article 4 of
13 title 24, C.R.S.
14 10-19-111. Right to return the policy and obtain refund
15 of premium. (1) An individual long-term care insurance
16 policyholder shall have the right to return the policy within
17 ten days of its delivery and to have the premium refunded if,
18 after examination of the policy, the policyholder is not
19 satisfied for any reason. Individual long-term care insurance
20 policies shall have a notice prominently printed on the first
21 page of the policy or attached thereto stating in substance
22 that the policyholder shall have the right to return the
23 policy within thirty days of its delivery and to have the
24 premium refunded if, after examination of the policy, the
25 policyholder is not satisfied for any reason.
26 (2) A person insured under a long-term care insurance
27 policy issued pursuant to a direct response solicitation shall

have the right to return the policy within thirty days of its delivery and to have the premium refunded if, after examination, the insured person is not satisfied for any reason. Long-term care insurance policies issued pursuant to a direct response solicitation shall have a notice prominently printed on the first page or attached thereto stating in substance that the insured person shall have the right to return the policy within thirty days of its delivery and to have the premium refunded if, after examination, the insured person is not satisfied for any reason.

10-19-112. Outline of coverage - certificate. (1) (a) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

(b) The commissioner shall prescribe a standard format, including style, arrangement, and overall appearance, and the content of an outline of coverage.

(c) In the case of agent solicitations, an agent shall deliver the outline of coverage prior to the presentation of an application or enrollment form.

(d) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

(2) The outline of coverage shall include all of the following:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions, and limitations contained in the policy;

(c) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described.

(d) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains the governing contractual provisions;

(e) A description of the terms under which the policy or certificate may be returned and premium refunded;

(f) A brief description of the relationship of cost of care and benefits.

(3) A certificate issued pursuant to a group long-term care insurance policy, which policy is delivered or issued for delivery in this state, shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions, and limitations contained in the policy; and

(c) A statement that the group master policy determines governing contractual provisions.

10-19-113. Compliance. No policy may be advertised,

1 marketed, or offered as long-term care or nursing home
2 insurance unless it complies with the provisions of this
3 article.
4 10-19-114. Severability. If any provision of this
5 article or the application thereof to any person or
6 circumstance is for any reason held to be invalid, the
7 remainder of the article and the application of such provision
8 to other persons or circumstances shall not be affected
9 thereby.
10 SECTION 2. Effective date. This act shall take effect
11 July 1, 1990.
12 SECTION 3. Safety clause. The general assembly hereby
13 finds, determines, and declares that this act is necessary
14 for the immediate preservation of the public peace, health,
15 and safety.

BILL 6

A BILL FOR AN ACT

1 CONCERNING THE REGULATION OF PERSONAL CARE BOARDING HOMES.

Bill Summary

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

In statutes governing the regulation of personal care boarding homes, amends the definition of "personal care boarding home" to clarify that the term includes facilities that provide described services directly or indirectly. Eliminates a cap on total fees that can be collected from each licensed facility by the health department. Allows the health department to impose a civil penalty against unlicensed homes. Creates the personal care boarding home cash fund, comprised of licensing fees and civil penalties collected by the department, to fund the department's administrative costs. Requires a criminal history check of personal care boarding home owners, operators, administrators, and staff. Prohibits the issuance of a license to persons convicted of certain crimes. Provides for the issuance of provisional licenses for applicants who are temporarily unable to conform to all minimum standards.

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

3 SECTION 1. 25-27-102 (8), Colorado Revised Statutes,

4 1989 Repl. Vol., is REPEALED AND REENACTED, WITH AMENDMENTS,

5 to read:

6 25-27-102. Definitions. (8) "Personal care boarding

1 home" or "home" means a residential facility that makes

2 available to three or more adults not related to the owner of

3 such facility, either directly or indirectly through a

4 provider agreement, room and board and personal services,

5 protective oversight, and social care due to impaired capacity

6 to live independently, but not to the extent that regular

7 twenty-four-hour medical or nursing care is required. The

8 term "personal care boarding home" does not include a facility

9 holding a current certificate of authority to operate as a

10 life care facility issued pursuant to article 13 of title 12,

11 C.R.S., or residential care facilities for the

12 developmentally disabled.

13 SECTION 2. 25-27-103, Colorado Revised Statutes, 1989

14 Repl. Vol., is amended to read:

15 25-27-103. License required - criminal and civil

16 penalties. (1) On or after July 1, 1986, it is unlawful for

17 any person, partnership, association, or corporation to

18 conduct or maintain a personal care boarding home without

19 having obtained a license therefor from the department of

20 health. Any person who violates this provision:

21 (a) IS guilty of a misdemeanor and, upon conviction

22 thereof, shall be punished by a fine of not less than fifty

23 dollars nor more than five hundred dollars;

24 (b) SHALL BE SUBJECT TO A CIVIL PENALTY ASSESSED BY THE

25 DEPARTMENT OF NOT LESS THAN FIFTY DOLLARS NOR MORE THAN ONE

26 HUNDRED DOLLARS FOR EACH DAY THE FACILITY VIOLATES THIS

27 SECTION. THE ASSESSED PENALTY SHALL ACCRUE FROM THE DATE THE

FACILITY IS FOUND BY THE DEPARTMENT TO BE IN VIOLATION OF THIS SECTION. THE ASSESSMENT, ENFORCEMENT, AND COLLECTION OF THE PENALTY SHALL BE BY THE DEPARTMENT IN ACCORDANCE WITH ARTICLE 4 OF TITLE 24, C.R.S., FOR CREDIT TO THE PERSONAL CARE BOARDING HOME CASH FUND CREATED PURSUANT TO SECTION 25-27-107.5.

SECTION 3. 25-27-104 (2) (a), Colorado Revised Statutes, 1989 Repl. Vol., is amended, and the said 25-27-104 (2) is further amended BY THE ADDITION OF A NEW PARAGRAPH, to read:

25-27-104. Minimum standards for personal care boarding homes - rules. (2) (a) Compliance with all applicable zoning, housing, fire, sanitary, and other codes and ordinances of the city, city and county, or county where the home is situated, TO THE EXTENT THAT SUCH CODES AND ORDINANCES ARE CONSISTENT WITH THE FEDERAL "FAIR HOUSING AMENDMENT ACT OF 1988", AS AMENDED, 42 U.S.C., SEC. 3601 ET SEQ.;

(g) That the administrator and staff of a home meet minimum educational, training, and experience standards established by the state board, including a requirement that such persons be of good, moral, and responsible character. In making such a determination, the owner or licensee of a home may have access to and shall obtain any criminal history record information from a criminal justice agency, subject to any restrictions imposed by such agency, for any person responsible for the care and welfare of residents of such facility.

SECTION 4. 25-27-105 (3), Colorado Revised Statutes,

1989 Repl. Vol., is amended, and the said 25-27-105 is further amended BY THE ADDITION OF THE FOLLOWING NEW SUBSECTIONS, to read:

25-27-105. License - application - inspection - issuance. (2.5) (a) As part of any investigation for a license issued or renewed pursuant to this article, the department shall obtain criminal history record information concerning the owner, applicant, or licensee of a home from a criminal justice agency, subject to any restrictions imposed by such agency.

(b) The information shall be used by the department in ascertaining whether the person being investigated has been convicted of a felony or of a misdemeanor involving moral turpitude or involving conduct that the department determines could pose a risk to the health, safety, and welfare of residents of the personal care boarding home. Information obtained in accordance with this section shall be maintained by the department.

(c) All costs of obtaining any information from a criminal justice agency pursuant to this section shall be borne by the individual who is the subject of such check.

(2.8) No license shall be issued or renewed by the department if the owner, applicant, or licensee of the personal care boarding home has been convicted of a felony or of a misdemeanor involving moral turpitude or involving conduct which the department determines could pose a risk to the health, safety, and welfare of the residents of the

personal care boarding home.

(3) EXCEPT AS OTHERWISE PROVIDED IN SUBSECTION (4) OF THIS SECTION, the department shall issue or renew a license when it is satisfied that the applicant or licensee is in compliance with the requirements set out in this article and the regulations promulgated thereunder. EXCEPT FOR PROVISIONAL LICENSES ISSUED IN ACCORDANCE WITH SUBSECTION (4) OF THIS SECTION, a license issued or renewed pursuant to this section shall expire one year from the date of issuance or renewal.

(4) The department may issue a provisional license to an applicant for the purpose of operating a personal care boarding home for a period of ninety days if the applicant is temporarily unable to conform to all the minimum standards required under this article; except that no license shall be issued to an applicant if the operation of the applicant's facility will adversely affect the health, safety, and welfare of the residents of such facility. As a condition of obtaining a provisional license the applicant shall show proof to the department that attempts are being made to conform and comply with applicable standards. No provisional license shall be granted prior to the completion of a criminal background check in accordance with subsection (2.5) of this section. A provisional license shall not be renewed.

SECTION 5. 25-27-106, Colorado Revised Statutes, 1989 Repl. Vol., is amended BY THE ADDITION OF A NEW SUBSECTION to read:

25-27-106. License denial, suspension, or revocation. (3) The department shall revoke or refuse to renew the license of a facility where the owner or licensee has been convicted of a felony or misdemeanor involving moral turpitude or involving conduct which the department determines could pose a risk to the health, safety, and welfare of the residents of such facility. Such revocation or refusal shall be made only after a hearing is provided in accordance with article 4 of title 24, C.R.S.

SECTION 6. 25-27-107, Colorado Revised Statutes, 1989 Repl. Vol., is amended to read:

25-27-107. License fee. (1) A nonrefundable fee of fifty dollars shall be submitted to the department with an application for an original or renewal license to operate a personal care boarding home, and an additional fee of ten dollars per available bed in the facility shall be submitted to the department once the applicant is notified that the application has been approved. ~~except--that--the--total--fees shall-not-exceed-two-hundred-fifty-dollars.~~

(2) THE FEES COLLECTED PURSUANT TO SUBSECTION (1) OF THIS SECTION SHALL BE TRANSMITTED TO THE STATE TREASURER, WHO SHALL CREDIT THE SAME TO THE PERSONAL CARE BOARDING HOME CASH FUND CREATED IN SECTION 25-27-107.5.

SECTION 7. Part 1 of article 27 of title 25, Colorado Revised Statutes, 1989 Repl. Vol., is amended BY THE ADDITION OF A NEW SECTION to read:

25-27-107.5. Personal care boarding home cash fund

1 created. The fees collected pursuant to section 25-27-107,
2 plus any civil penalty collected pursuant to section 25-27-103
3 (2) (b), shall be transmitted to the state treasurer, who
4 shall credit the same to the personal care boarding home cash
5 fund, which fund is hereby created. The moneys in the fund
6 shall be subject to annual appropriation by the general
7 assembly for the direct and indirect costs of the department
8 in performing its duties under this article. At the end of
9 any fiscal year, all unexpended and unencumbered moneys in the
10 fund shall remain therein and shall not be credited or
11 transferred to the general fund or any other fund.
12 SECTION 8. Effective date. This act shall take effect
13 July 1, 1990.
14 SECTION 9. Safety clause. The general assembly hereby
15 finds, determines, and declares that this act is necessary
16 for the immediate preservation of the public peace, health,
17 and safety.

BILL 7

A BILL FOR AN ACT

1 CONCERNING THE INCLUSION OF HOSPICE CARE AS A SERVICE UNDER
2 THE "COLORADO MEDICAL ASSISTANCE ACT", AND MAKING AN
3 APPROPRIATION THEREFOR.

Bill Summary

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

Includes hospice care as a service for medicaid-eligible persons under the "Colorado Medical Assistance Act". Defines "hospice care". Requires the state board of social services to promulgate rules and regulations concerning the provision of hospice care. Makes an appropriation.

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4 Be it enacted by the General Assembly of the State of Colorado:
5 SECTION 1. 26-4-103, Colorado Revised Statutes, 1989
6 Repl. Vol., is amended BY THE ADDITION OF A NEW SUBSECTION to
7 read:
8 26-4-103. Definitions. (3.3) "Hospice care" means
9 services provided by a public agency or private organization,
10 or any subdivision thereof, which entity shall be known as a
11 hospice and shall be primarily engaged in providing care to an

1 individual for whom a certified medical prognosis has been
2 made indicating a life expectancy of six months or less and
3 who has elected to receive such care in lieu of other medical
4 benefits available under this article.
5 SECTION 2. 26-4-105 (1), Colorado Revised Statutes, 1989
6 Repl. Vol., is amended BY THE ADDITION OF A NEW PARAGRAPH to
7 read:
8 26-4-105. Basic services for categorically needy.
9 (1) (s) Hospice care for a period of up to two hundred ten
10 days in accordance with rules and regulations adopted by the
11 state board, which rules and regulations shall comply with
12 section 1905 of the social security act, 42 U.S.C., sec.
13 1396d, and shall include at least the following requirements:
14 (I) That a person shall obtain a certified medical
15 prognosis indicating a life expectancy of six months or less,
16 which certification shall comply with rules and regulations
17 adopted by the state board;
18 (II) That a person shall execute a waiver of other
19 medical benefits available under this article, which election
20 shall be executed in accordance with rules and regulations
21 adopted by the state board;
22 (III) That the service shall be reasonable and necessary
23 for the palliation or management of the terminal illness and
24 related conditions.
25 SECTION 3. Appropriation. (1) In addition to any other
26 appropriation, there is hereby appropriated, out of any moneys
27 in the general fund not otherwise appropriated, to the state

1 department of social services, for the fiscal year beginning
2 July 1, 1990, the sum of three hundred eighty-three thousand
3 four hundred twenty dollars ($383,420), or so much thereof as
4 may be necessary, for hospital program costs and fifty-eight
5 thousand one hundred fifty dollars ($58,150) and 0.5 FTE, or
6 so much thereof as may be necessary, for administrative costs,
7 both of which shall be costs incurred by the state department
8 in implementing this act. Of said sum, two hundred twelve
9 thousand six hundred ninety-five dollars ($212,695) shall be
10 out of any moneys in the general fund not otherwise
11 appropriated, and two hundred twenty-eight thousand eight
12 hundred seventy-five dollars ($228,875) shall be from federal
13 funds.

14 (2) In addition to any other appropriation, there is
15 hereby appropriated, to the state department of social
16 services, for the fiscal year beginning July 1, 1990, the sum
17 of four hundred fifty-nine thousand six hundred ten dollars
18 ($459,610), or so much thereof as may be necessary, for
19 hospital and medical expenses incurred by the state department
20 in implementing this act. Of said sum, two hundred
21 thirty-nine thousand five hundred three dollars ($239,503)
22 shall be out of any moneys in the general fund not otherwise
23 appropriated, and two hundred twenty thousand one hundred
24 seven dollars ($220,107) shall be from federal funds.

25 SECTION 4. Effective date. Sections 1 and 2 of this act
26 shall take effect January 1, 1991, or upon the development and
27 implementation of a uniform assessment instrument by the state

1 department, whichever occurs earlier, and sections 3, 4, and 5
2 shall take effect upon passage.

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

BILL 8

A BILL FOR AN ACT

1 CONCERNING THE DEVELOPMENT OF A CASE MANAGEMENT SYSTEM FOR
2 CERTAIN PUBLICLY ASSISTED DISABLED PERSONS IN NEED OF
3 LONG-TERM CARE, AND MAKING AN APPROPRIATION THEREFOR.

Bill Summary

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

Requires the governor to select a department to conduct a case management study of disabled clients of the departments of institutions and social services with mental impairments and to develop and administer a pilot project using a case management system for the delivery of services to specified disabled clients of such departments. Requires that the study be focused on an urban area of the state and that the project be conducted in a rural area. Directs that the case management system to be used for the pilot project be an independent system which shall be designed by a project director appointed by the executive director of the designated department.

Creates an advisory committee to advise and assist the executive director of the designated department in conducting the study and in selecting a project director to design the case management system for the pilot project; to make recommendations to the project director concerning the design of the independent case management system; and to assist and advise the executive director in evaluating the pilot project.

Requires the designated department to submit the results of the study and findings concerning the pilot project, including a recommendation as to the feasibility of the statewide implementation of the independent case management system, to the general assembly by a specified date.

Makes an appropriation.

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1 Be it enacted by the General Assembly of the State of Colorado:
2 SECTION 1. Title 26, Colorado Revised Statutes, 1989
3 Repl. Vol., is amended BY THE ADDITION OF A NEW ARTICLE to
4 read:
5 ARTICLE 4.7
6 Case Management System
7 26-4.7-101. Definitions. (1) As used in this article,
8 unless the context otherwise requires:
9 (a) "Case management" means a single point of entry and
10 coordination of services with uniform eligibility
11 requirements, an assessment of the individual's strengths and
12 weaknesses, a coordinated plan for needed services developed
13 by the individual, family members, when appropriate, and an
14 inter-disciplinary team with goals and measurable objectives,
15 periodic review, and ongoing monitoring of the service
16 delivery. Case management may be developed as an independent
17 system in which the case manager acts as an advocate for the
18 individual and serves as a broker to locate and purchase
19 appropriate services for the individual. Case management may
20 also be developed in conjunction and cooperation with the
21 direct service providers.
22 (b) "Designated department" means the department
23 selected by the governor in accordance with section 26-4.7-102
24 to perform functions under this article.
25 (c) "Disabled client" means a disabled person, as

defined in paragraph (d) of this subsection (1) who receives assistance from the departments of institutions or social services and who is in need of long-term care as such term is defined in paragraph (e) of this subsection (1); except that "disabled client" does not include a person with developmental disabilities as defined in section 27-10.5-102 (10) (b), C.R.S.

(d) "Disabled person" means an individual who has physical impairment or mental impairment which substantially limits one or more of a person's major life activities, for whom there exists a record of such an impairment, and who is generally regarded as having such an impairment.

(e) "Long-term care" means those services designed to provide diagnostic, preventive, therapeutic, rehabilitative, supportive, and maintenance services for individuals who have chronic physical or mental impairments, or both, in a variety of institutional and noninstitutional settings, including the home, with the goal of promoting the optimum level of physical, social, and psychological functioning of such individuals.

(f) "Mental impairment" means any mental or psychological disorder such as mental retardation, organic brain syndrome, emotional or mental illness, or specific learning disabilities.

26-4.7-102. Case management system - study - pilot project. (1) The governor shall designate a principal department of state government to:

(a) Conduct or cause to be conducted a study of the delivery of case management services to disabled clients who have mental impairments and are in need of long-term care. The study shall be conducted in accordance with subsection (2) of this section.

(b) Develop and implement a pilot project to study the statewide use of an independent case management system for disabled clients who are in need of long-term care. The pilot project shall be conducted in accordance with subsection (3) of this section.

(2) (a) The study required in subsection (1) (a) of this section shall be focused on an urban area of the state, shall be of disabled clients with mental impairments only, and shall be completed on or before July 1, 1991. The executive director of the designated department may contract with a public or private individual or organization to conduct the study; except that the study shall not be conducted by any person or entity that provides case management services to disabled persons.

(b) The study shall include at a minimum an evaluation of the following:

(I) The feasibility and cost-effectiveness of the current case management system for disabled clients who are in need of long-term care;

(II) Client impact under the current case management system for disabled clients. The evaluation of client impact shall be based, in part, on an assessment of client

satisfaction obtained through a client survey. In addition, the evaluation shall include a determination as to whether the current case management system provides a variety of choices of care to an informed clientele.

(III) The citywide demonstration project being conducted in the city and county of Denver, based on a comparison of such project and the case management system currently used for disabled clients elsewhere in the state;

(IV) The feasibility and cost-effectiveness of establishing an independent case management system for disabled clients in need of long-term care;

(V) The delivery, administrative structure, and financing implications of case management services for all disabled persons.

(c) The designated department shall report the results of the study to the general assembly no later than January 1, 1992.

(3) (a) On or after July 1, 1991, the designated department shall develop and implement a pilot project in a rural area of the state to study the statewide implementation of an independent case management system for disabled clients as defined in section 26-4.7-101 (1) (c).

(b) The executive director shall appoint a project director who shall design an independent case management system for the pilot project. In designing the pilot case management system, the project director shall follow guidelines established by the executive director. The

guidelines shall include, but shall not be limited to, requiring that:

(I) Case management be provided by private individuals or nonprofit organizations and not by long-term care service providers or public agencies that provide assistance to disabled clients;

(II) The project director consider any recommendations made by the advisory committee created in section 26-4.7-103 in designing the system.

(c) The executive director, with the assistance of the advisory committee created in section 26-4.7-103, shall evaluate the overall effectiveness of the case management system and shall submit written findings and recommendations concerning the establishment and operation of a statewide case management system to the general assembly no later than January 1, 1993. The written findings and recommendations shall specifically address the following:

(I) The feasibility and cost-effectiveness of establishing an independent case management entity for disabled persons in the state who are clients of the departments of education, health, institutions, and social services;

(II) The delivery, administrative structure, and financing implications of an independent case management services for disabled persons in all areas of the state.

(4) Any state agency providing services to disabled clients shall cooperate with the designated department in

1 performing its duties under this section.
2 (5) The designated department shall promulgate rules
3 and regulations necessary for the implementation of this
4 section.
5 26-4.7-103. Case management committee created.
6 (1) There is hereby established a case management committee
7 which, in accordance with section 26-4.7-102, shall advise and
8 assist the executive director of the designated department in
9 conducting the case management study and in selecting a
10 project director to design the case management system for the
11 pilot project; shall make recommendations to the project
12 director concerning the design of the independent case
13 management system; and shall assist and advise the executive
14 director in evaluating the pilot project.
15 (2) (a) The committee shall be made up of the following
16 members:
17 (I) One representative from each of the several boards
18 of county commissioners; one representative from each of the
19 several county departments of social services, and one
20 representative from each community mental health centers.
21 Such representatives shall be selected by the respective
22 boards of county commissioners. Where such entities serve a
23 geographical area comprised of more than one county, the
24 boards of county commissioners for such area shall appoint one
25 representative from the particular entity servicing the area.
26 (II) One representative from the Colorado
27 developmentally disabled planning council;

1 (III) One representative from the state department of
2 social services and the department of institutions selected by
3 the executive directors of such departments.
4 (3) This section is repealed effective January 1, 1993.
5 26-4.7-104. Repeal. This article is repealed, effective
6 January 1, 1993.
7 SECTION 2. Appropriation. There is hereby appropriated,
8 to the department designated pursuant to section 26-4.7-102
9 (1), Colorado Revised Statutes, for the fiscal year commencing
10 July 1, 1990, the sum of ________ dollars ($), or so
11 much thereof as may be necessary, for the implementation of
12 this act. Of said sum, ________ dollars ($) shall be
13 from any moneys in the general fund not otherwise
14 appropriated, and ________ dollars ($) shall be from
15 federal funds.
16 SECTION 3. Effective date. This act shall take effect
17 July 1, 1990.
18 SECTION 4. Safety clause. The general assembly hereby
19 finds, determines, and declares that this act is necessary
20 for the immediate preservation of the public peace, health,
21 and safety.

SENATE JOINT RESOLUTION NO. 1

SENATE JOINT RESOLUTION 90-

1 WHEREAS, Older Americans are the largest users of health
2 care, accounting for over $145 billion, about one-third of the
3 nation's health bill in 1988; and the total cost to society
4 from Alzheimer's Disease is now estimated to be $80 billion
5 annually; and

6 WHEREAS, Today, Alzheimer's Disease and related disorders
7 affect more than 4 million Americans, 7 to 9 percent of
8 persons over age 65 and about 25 percent of persons over age
9 85, and is the fourth leading cause of adult death in this
10 country; at least 25 percent of Americans in their 20's and
11 30's will develop the disease before they die if a cure is not
12 found; and as more people live to an older age, the incidence
13 of Alzheimer's Disease will rise dramatically; and

14 WHEREAS, The aging of the population from the year 1990
15 through the year 2000 will significantly increase the number
16 of nursing home residents; and thereby add to the number of
17 nursing home residents who have Alzheimer's Disease, which
18 increase will have a serious impact on the health care system
19 of the United States; and

20 WHEREAS, Expenditures on nursing homes have increased
21 dramatically over the past decade; and nearly one-half of
22 these costs is now borne by the states and the federal
23 government, almost entirely through Medicaid, at a current
24 cost for Alzheimer's Disease alone estimated to exceed $12
25 billion per year; and

26 WHEREAS, Alzheimer's Disease is widely recognized as
27 placing an enormous financial, physical, and emotional burden
28 on family caregivers; and

29 WHEREAS, Current research expenditures for Alzheimer's
30 Disease amount to less than $30 per patient compared to an
31 average of $22,000 spent in 1988 to care for Alzheimer's
32 patients; and if scientists do not find a way to cure or treat
33 Alzheimer's Disease by the end of this century, the number of
34 patients will double simply because of the demographic shift

1 that is occurring; and

2 WHEREAS, Medical research offers the only hope for
3 understanding and eventually eliminating Alzheimer's Disease;
4 now, therefore,

5 Be It Resolved by the Senate of the Fifty-seventh General
6 Assembly of the State of Colorado, the House of
7 Representatives concurring herein:

8 That, although notable scientific advances have been made
9 in recent years, the Congress of the United States is strongly
10 urged to increase federal support to address some of the major
11 issues still surrounding Alzheimer's Disease, including
12 identifying the underlying cause or causes; developing a
13 diagnostic screen that can identify the presence of this
14 disorder prior to the presence of clinical signs; and
15 investigating the application of drugs or therapeutic agents
16 that could aid in the treatment of the disease.

17 Be It Further Resolved, That each member of Congress from
18 the State of Colorado give full support to such legislation.

19 Be It Further Resolved, That copies of this resolution be
20 sent to the President of the United States, to the President
21 of the Senate and the Speaker of the House of Representatives
22 of the Congress of the United States, to the chairman of the
23 Senate Committee on Finance and the chairman of the House
24 Committee on Ways and Means, and to each member of Congress
25 from the State of Colorado.