Report to the Colorado General Assembly:

RECOMMENDATIONS FOR 1979
COMMITTEE ON:

Health, Environment, Welfare, and Institutions

I. Medically Indigent
II. Senior Citizens

COLORADO LEGISLATIVE COUNCIL

RESEARCH PUBLICATION NO. 239

December, 1978

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OF THE

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The Legislative Council, which is composed of six Senators, six Representatives, plus the Speaker of the House and the Majority Leader of the Senate, serves as a continuing research agency for the legislature through the maintenance of a trained staff. Between sessions, research activities are concentrated on the study of relatively broad problems formally proposed by legislators, and the publication and distribution of factual reports to aid in their solution.

During the sessions, the emphasis is on supplying legislators, on individual request, with personal memoranda, providing them with information needed to handle their own legislative problems. Reports and memoranda both give pertinent data in the form of facts, figures, arguments, and alternatives.

COLORADO LEGISLATIVE COUNCIL

RECOMMENDATIONS FOR 1979

COMMITTEE ON HEALTH, ENVIRONMENT WELFARE, AND INSTITUTIONS

Legislative Council

Report To The

Colorado General Assembly

Research Publication No. 239
December, 1978

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December 15, 1978

To Members of the Fifty-second Colorado General Assembly:

Submitted herewith is the final report of the Legislative Council Committee on Health, Environment, Welfare, and Institutions for 1978. The report of the Health, Environment, Welfare, and Institutions Committee is one of a series of six volumes containing the reports of all of the Legislative Council committees.

Reports of eight other committees are consolidated in two volumes of Research Publication No. 236. The reports of the Committees on School Finance (Research Publication No. 235), Air Pollution (Research Publication No. 237), Transportation and Energy (Research Publication No. 238), and Judiciary - Sentencing Legislation (Research Publication No. 240), are contained in separate reports.

Respectfully submitted,

/s/ Representative Carl Gustafson
Chairman
Colorado Legislative Council

CG/vjk

FOREWORD

The recommendations of the Colorado Legislative Council for 1979 appear in two consolidated volumes and five separate reports.

Three topics were assigned to the Health, Environment, Welfare, and Institutions Committee this year, by action of the General Assembly or at the direction of the Legislative Council. The committee was assigned a review of state programs and policies for Colorado's senior citizens (S.J.R. 29); a study of Colorado's medically indigent program (S.J.R. 29); and a review of the state's placement of adjudicated youth in residential child care facilities (by direction of the Legislative Council).

The Legislative Council reviewed this report and recommendations at its meeting on November 27, 1978, and transmits the seven bills and two resolutions included herein with favorable recommendation to the 1979 session of the General Assembly.

The committee and staff of the Legislative Council were assisted by Pat Lobo and John Polak of the Legislative Drafting Office in the preparation of bills contained in this report.

December, 1978

Lyle C. Kyle
Director

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COMMITTEE ON HEALTH, ENVIRONMENT,
WELFARE, AND INSTITUTIONS

Introduction

The assignment to the Interim Committee on Health, Environment, Welfare, and Institutions, contained in Senate Joint Resolution No. 29, included two primary areas of study: health care for the medically indigent; and senior citizens. Additionally, the committee was authorized by the Legislative Council to study residential child care facilities (RCCF's).

Organization of committee. In effect, the committee functioned as two separate committees, dividing its time between a study of the medical and program needs of indigent persons in Colorado, and a review of state-funded programs for the elderly. Two special committee meetings were called to meet with executive and judicial officials who are responsible for the placement and care of children in residential child care facilities.

Objective of committee. The committee interpreted its responsibility relative to the study of the medically indigent by a strict reading of the study directive, which included an identification of:

a) the numbers of medically indigent persons in Colorado, the types of their medical problems, and the geographical distribution of such persons and problems throughout the state;

b) the need for statutes of a general and permanent nature to govern the medically indigent program;

c) how moneys appropriated by the state and local governments for the medically indigent program are being spent and the proportion of the cost of the program which is properly borne by each level of government and by providers;

d) the means of improving the accessibility of services and of providing services as close as is practicable to the place of the patient's residence and relating funding to patterns of patient flow; and

e) the role of Colorado General Hospital, other public hospitals, public health clinics, private health care providers including but not limited to nonprofit hospitals and physicians, and other facilities and providers in the delivery of services to the medically indigent and the availability of specific medical services through such facilities and providers throughout the state.

While the directive concerning senior citizens called for the development of a comprehensive state policy on senior citizens, the

committee viewed its primary responsibility as one of reviewing and compiling an inventory of those activities of the state executive departments which are directed toward senior citizens. As will be observed later in this report, the committee was particularly diligent in its review of the activities of the Division of Services for the Aging.

Scope of final report. The purpose of this report is to summarize committee activity in the three primary areas of study and to forward committee recommendations for consideration by the General Assembly.

The report is divided into two sections -- Committee Recommendations and the Background Report.

The background report (starting on page 16) contains the data and material upon which the committee based its recommendations. Also included in the background report is the inventory of state-funded programs for senior citizens which was called for in the study directive.

COMMITTEE RECOMMENDATIONS

The committee recommends seven bills and two resolutions for consideration by the General Assembly during the 1979 session: Three bills relating to a health program for the medically indigent (Bills 47 through 49); two bills relative to residential child care facilities (Bills 50 and 51); one bill concerning community mental health centers (Bill 52); one bill concerning alternatives to nursing home care (Bill 53); and two joint resolutions pertaining to programmatic and administrative matters involving the state's administration of programs for senior citizens (Bills 54 and 55).

Medically Indigent

The state's current Medically Indigent Program is authorized by a footnote in the long appropriations bill. For fiscal year 1978-79, $10,000,000 is appropriated for the care of medically indigent persons in hospitals owned by municipalities, counties, and hospital districts, and private and non-profit hospitals. Of this appropriation, $100,000 is earmarked for physician services provided through participating hospitals.

The committee recommends three alternative proposals which will each have the effect of providing permanent statutory authorization for a medical program for indigent persons.

Bill 47 -- Providing for State Reimbursement for Part of the Cost of Medical Care and Service Rendered to Indigent Persons, and Making an Appropriation Therefor

This bill will provide statutory authority for the state's Medically Indigent Program which is currently authorized in the long appropriations bill.

The significant aspects of the program are:

Recipient. A recipient is a person who because of his family size and income is unable to pay for necessary medical care. An individual's participation will be based on a sliding fee scale to be established annually in the long appropriations bill and by rule and regulation of the State Board of Social Services.

Currently, an indigent patient is one whose income falls within the parameters set forth in the Colorado General Hospital Inpatient and Outpatient Ability-to-Pay Scale, effective July 1, 1978.

Health providers. The providers of medical care under Bill 47 will be identical to those currently enumerated in the long appropriations bill: hospitals and health clinics owned and operated by municipalities, counties, and hospital districts; private and non-profit hospitals; and licensed physicians who provide services through these hospitals and clinics.

Reimbursement. The formula for reimbursement to a health provider will be established annually in the long appropriations bill and by rule and regulation of the State Board of Social Services. Currently, the 1978 long appropriations bill sets the reimbursement for inpatient and outpatient care at a rate not to exceed charges for similar care and indigency at Colorado General Hospital or actual charges, whichever is less.

A health provider will be eligible to apply for participation in the program, providing their expenditures for indigent care exceeds three percent of the facilities' gross operating expenditures after the deduction of all federal reimbursement.

With regard to reimbursement for physicians, the State Board of Social Services will be authorized to determine the percentage of funds which will be allocated for physician services. In 1978, the General Assembly determined that $100,000 would be appropriated for physician services at the 1978-79 established Medicaid rate.

All reimbursements under this bill will be subject to available funds.

Administration. The program will continue to be administered by the Department of Social Services.

Bill 48 -- Providing for Medical Services for the Medically Indigent and Making an Appropriation Therefor

The intent of Bill 48 is to provide a statewide program for medical care for persons whose medical expenses represent a high percentage of their income.

Eligibility for program. The State Board of Social Services will establish, by rule and regulation, a formula for determining eligibility for the program. The formula will relate a person's medical expenses as a percentage of their income in order to determine eligibility for the state program. Currently, the size of the family and the family income are the only factors used to determine eligibility, and the extent of a person's accumulated medical expenses is not taken into account.

Participation in the program will be contingent upon a person having incurred a stated percentage of his income for medical expenses for the immediately preceding twelve months. The determination of eligibility will be based upon proof of family income by using Colorado income tax returns covering the same time period, and bills or written charges for medical expenses. A person seeking assistance under the program will be responsible for producing the necessary income tax returns and medical bills which will be used in determining his eligibility for the program.

Copayment. The State Board of Social Services will establish, by rule and regulation, a copayment schedule in order to allow the person who qualifies for the state program to pay a proportional share of the cost of his medical expenses, with the remainder to be paid by the state up to a maximum dollar figure.

Control. The State Board of Social Services will be authorized to establish a list of priority medical services which will be covered by the program. It is the intent of Bill 48 to limit the cost of the program and to provide services within the limits of the appropriation made by the General Assembly.

Health providers. The providers of medical services under this bill will be private or public general hospitals, community clinics, private physicians, free standing kidney dialysis centers, and health maintenance organizations.

Administration. The program will be administered by the Department of Social Services. The Board of Social Services will designate, by rule and regulation, a hospital in each of the three health service areas of the state to contract with health providers in their health service area to deliver the medical services included in the program. The three primary hospitals will be selected on the basis of operating costs of the hospital and costs of services provided -- the intent being to select the lowest cost providers. The appropriation for the program will be allocated to the three primary

hospitals, and these hospitals will in turn contract directly with other health providers in the health service area.

Bill 49 -- Concerning a Medical Assistance Program for Handicapped Children and Medically Indigent Persons, and Making an Appropriation Therefor

The intent of Bill 49 is to consolidate three currently independent programs -- Handicapped Children's Program (Department of Health), Colorado General Hospital appropriation for indigent care (Department of Higher Education), and the Medically Indigent Program (Department of Social Services). The consolidated program will be administered by the Department of Health, with a single appropriation being made.

It is the intent of the program to ensure geographic accessibility to medically indigent services by authorizing the Department of Health to develop contracts in various areas of the state with health service providers, including physician's organizations, hospitals, and health maintenance organizations. The intent is to contract with the lowest cost providers to deliver medical services as close to a person's home as is practicable.

Medical services and control. The Department of Health will establish a list of priority medical services and care, emphasizing perinatal and child care. The contracts which the department will enter into and the allocations which will be made will correspond to the priority medical services which the department will establish. At such time that encumbrances or expenditures for a fiscal year reach a minimum level (as yet undetermined), the Department of Health will have the authority to delay treatment of certain non-emergency conditions until the start of the next program year.

Eligibility. The Department of Health will establish an ability-to-pay scale to be used in determining eligibility for the program.

Health provider participation. Participation of hospitals in the program will continue to be based on the current requirement that the facility provide a fixed percentage of free care (as yet undetermined) prior to becoming eligible for reimbursement. The current requirement that each participating facility be audited within 90 days of the end of the program year will be eliminated.

Reimbursement. Under the program, physicians will be reimbursed for their services at the approved Medicare rate, or at a rate set by the Department of Health by negotiation with providers. Hospitals will be reimbursed at a rate approved by the Colorado Hospital Commission.

In the provision of physician services to indigent patients, "assignment" will be mandatory -- assignment being a process where

medical services are assured to an eligible patient, and where the patient cannot later be billed for the services.

Residential Child Care Facilities

The committee's study of residential child care facilities (RCCF's) was authorized by the Legislative Council at its meeting of August 4, 1978. The issues to which the committee directed its attention were: 1) the negotiation of new contracts between the State Department of Social Services and Colorado RCCF's; and 2) the placement by juvenile courts of adjudicated youth in out-of-state RCCF's.

Residential child care facilities are group treatment facilities for children who have been placed there by outside agencies or by the juvenile court. These facilities provide rehabilitation to children with problems ranging from emotional difficulties to juvenile delinquency.

Negotiation of Contracts Between the State Department of Social Services and Colorado RCCF's

In the 1978 long bill, a new formula was created by which the State Department of Social Services would determine the rate at which RCCF's are to be reimbursed for the care of children placed in RCCF facilities by the state. This formula created a new ceiling for such reimbursement for various categories of facilities. This formula, as explained in the 1978-79 Appropriations Report states:

> The Department shall set rates for the five categories of facilities (severe, moderate, mild, developmentally disabled, and special) which will not exceed a ceiling for each category. That ceiling shall be determined at the 90th percentile of facilities rates in each category. Thus, in any given category, 90% of the facilities are currently providing programs at or under the ceiling rate. The ceiling rate will be determined excluding education costs, which will be treated as an add-on cost. (p. 130)

After the authorization of these new guidelines which were to become effective as of July 1, 1978, the Department of Social Services began negotiating new contracts with RCCF's based on these maximum reimbursement rates. In this negotiation process, many RCCF's refused to accept new contracts, based on their opinion that these new maximum rates were insufficient to cover their costs of providing adequate care.

On July 25, the Joint Budget Committee met with staff from the Department of Social Services to consider this difficulty in securing contracts with RCCF's. The JBC voted at that time to remove some of

the restrictions that were contained in the long bill formula. On August 4, the State Board of Social Services authorized the department to continue negotiations with the RCCF's, and the board determined that these re-negotiations would be conducted under certain guidelines, as the JBC decision to relax the previous restrictions contained no new limits. The new guidelines were that contracted services would continue at the same basic level as prior years, but allowing for a percentage increase in their cost due to inflation. The increased reimbursement rate would not allow for additional services provided by the RCCF, nor would additional staff positions be allowed. The re-negotiation, with relaxed restrictions, was to include only Colorado-based RCCF's, not those located outside of the state.

The re-negotiation process resulted in the development of continuation contracts with all participating Colorado RCCF's with the exception of one, Frontier Boys' Ranch, which ceased operation rather than accept the rate offered to them.

Juvenile Court Procedures in RCCF Placements

The Colorado Children's Code, section 19-3-112 (d), C.R.S. 1973, contains a provision that gives the juvenile court fairly broad latitude in placing adjudicated delinquents or "children needing oversight" in residential facilities:

> (d) The court may place legal custody in the county department of social services or a child placement agency for placement in a family care home or child care facility, or it may place the child in a child care center.

In section 19-1-103, C.R.S. 1973, "child care center" is defined as "...a facility licensed and approved pursuant to law. If such facility is located in another state, it shall be licensed or approved as required by law in that state."

The 1978 long bill, in footnote 67A, requires that court placements be only to facilities that are not only licensed, but also approved by the Department of Social Services. This requirement was meant to ensure that all RCCF placements be to facilities that have contracted at the Department of Social Services' approved reimbursible rate. Also, this was intended to discontinue the placement of children in these expensive, out-of-state facilities.

In an effort to implement this requirement contained in footnote 67A, the Chief Justice of the Supreme Court sent a memorandum in June, 1978, to all juvenile courts asking them to be guided accordingly by this restriction in the disposition of their juvenile cases after July 1, 1978, the effective date of the footnote.

In testimony before the committee in August, it was learned

that a number of children had been placed in out-of-state RCCF's by juvenile courts since July 1. It appeared to the committee that these out-of-state placements had been made in apparent contradiction to the footnote directive. As a result, the committee requested an explanation of the situation from the former Chief Justice.

In his response to the committee, the former Chief Justice stated that the juvenile judges had not intended to circumvent the footnote directive, but that out-of-state placements had been necessitated by the refusal of Colorado facilities to accept for treatment the children in question. In each case, the out-of-state placement was made with either the recommendation or concurrence of the respective county department of social services on the basis of the unavailability of a suitable licensed Colorado facility. In his letter of reply, the former Chief Justice stated:

> It appears that facilities for these children are becoming less and less available in Colorado, in part, because it is contended that amounts paid by the state are not sufficient to maintain a program without taking in children from other states at higher rates.

Testimony From State Department of Social Services

At its August 17 meeting, the committee was informed that there were currently 98 children placed in out-of-state facilities. For the month of June, the department had calculated the average net payment (total payment less family or third-party contributions) to be $1,546 per child for that month. It was noted that the maximum monthly reimbursement paid for an out-of-state placement was $3,600 to a facility in Texas. The projected annual payment by the state for out-of-state services was said to be $1.6 million.

In response to the committee's request for additional data on RCCF placements, the department provided the committee with documentation on costs and comparisons of these services. The department supplied the following chart which reflects trends for the total in-state and out-of-state RCCF program from fiscal years 1971-72 through 1977-78:

FY	Average Monthly No. of Children	Annual Total Cost	Average Cost per month
1971-72	566	$ 2,137,374	$314.69
1972-73	623	3,317,475	443.75
1973-74	706	4,308,617	508.57
1974-75	830	5,975,273	599.65
1975-76	892	7,213,760	635.96
1976-77	1,020	8,765,431	716.13
1977-78	1,124	11,526,154	854.32

The department reported that data was not available for in-state and out-of-state placements separately, though they calculated the FY 1977-78 total net payment by the department for out-of-state services as $1,089,907.

In reference to any trends evidenced over the past several years, it was stated in the department's report that "the number of children in out-of-state placements increased only slightly until the past couple of years when the number of out-of-state placements more than doubled due largely to withdrawal of spaces by some Colorado facilities because of our inability to pay what they consider to be costs necessary to operate their programs".

Diagnosis of Children for RCCF Placement

In the course of interim testimony on RCCF placements, a topic of discussion was the methods by which juvenile courts determine the treatment needs of adjudicated youth and, subsequently, selecting an appropriate treatment facility for placement.

A representative of the Department of Social Services explained that there is no formal screening procedure as such, but that in most counties the assessment of a youth's needs and the recommendations for placement are often the product of a cooperative effort between personnel from various agencies, including probation, county social service, and school personnel. It was noted, though, that the juvenile court is not obliged to follow the recommendation that might be made, as the judge has the option of exercising his own discretion over placement alternatives. The opinion was expressed in the discussion that some judges appear to prefer particular residential facilities for placement, in some cases expensive, out-of-state facilities.

Multidisciplinary assessment units. The committee discussed the concept of creating assessment teams in each county, made up of representatives from a variety of youth-serving agencies, to whom the juvenile court would refer adjudicated youth for the determination of treatment needs, and who would in turn place the youth in an appropriate, approved facility. The objective of this proposal would be to transfer placement authority from the juvenile court to the assessment teams in order to minimize the placement discretion that now exists in the system.

Juvenile court judges' response to assessment unit proposal. Judge Jon Lawritson from the Denver Juvenile Court had been appointed by the Colorado Association of Juvenile Court Judges to present the association's response to the committee.

Judge Lawritson explained that a proposal to remove the decision-making authority for RCCF placements from the court and place it with county departments of social services would reinstitute a method used previously and, in his opinion, with very poor results. In the past, juvenile courts made it a practice to place children with

the county departments and to allow them to make the placement decision.

Within the past several years, it became evident to the courts that the county departments were not adequately monitoring these placements. In their review of cases that were being supervised by the county department, the courts found that many children were remaining in placement facilities or state institutions for an extended period, that the departments were failing to request the courts' review of many of these placements, and that some children were being shuffled between numerous placement facilities.

Upon their determination that cases were being inadequately monitored, the courts developed a policy of auditing all children's placement cases. In April of 1974, the Denver Juvenile Court began an audit of all cases where the children could possibly be under the courts' jurisdiction, and where the children were in placements which the courts had not reviewed. Judge Lawritson explained that, by 1977, 3,081 cases were reviewed by the court, and the results were that all children in placement were reviewed, and permanent placement plans for these children were developed. Of the cases reviewed, the following results were accomplished:

45% placed for adoption
4% placed with relatives
9% returned to parents
26% found to be in inappropriate placements and transferred
16% remained in the same placement

Judge Lawritson stated that these reviews of cases in other states showed similar results, to the extent that the National Council of Juvenile Court Judges initiated a nationwide project for reviewing placement cases that were not court-monitored. The recommendations of the National Council that came as a result of the project's findings include the court's authority to review all placements of children.

Judge Lawritson concluded that checks and balances in all phases of government is necessary, including the out-of-home placement of children. By maintaining a system which provides for adversary proceedings in children's placement cases, the need for these placements will be more adequately justified.

Bill 50 -- Concerning Placement of Children Adjudicated to be Neglected or Dependent or Needing Oversight or Delinquent

Bill 50 will require juvenile courts to place children only in those residential child care facilities that are licensed and approved (under contract) with the Colorado Department of Social Services. The effect of this requirement will be to remove the juvenile court's authority to make placements in out-of-state facilities which have not contracted with the state at an approved reimbursement rate.

Bill 51 -- Concerning Placement of Children Pursuant to the Children's Code, and Establishing Multidisciplinary Assessment Units Therefor

Bill 51 will create local, multidisciplinary assessment teams, and will transfer to the teams the authority which is currently vested in the juvenile courts for placing children in residential child care facilities (RCCF's). The courts will retain the dispositional alternative of RCCF treatment for adjudicated children, but will place the child with the county department of social services rather than allowing the courts to place a child directly in a residential facility. The multidisciplinary assessment team will be situated within the county department, and will be governed by rules and regulations of the State Department of Social Services.

The assessment team will conduct a diagnostic evaluation of the treatment needs of the child, and subsequently place the child in an approved facility which will best serve the needs of that child. An approved facility is one which has a contractual agreement with the Colorado Department of Social Services to provide residential treatment at an agreed reimbursement rate. Placement can be made to an out-of-state facility providing appropriate services are not available within Colorado, and that the out-of-state facility is approved by the Colorado Department of Social Services.

The assessment unit will consist of: a physician; an attorney; and representatives of local law enforcement agencies, the juvenile court, the county department of social services, a local mental health clinic, the public health department, a local school district, and the lay community. All members of the assessment unit will be appointed by the director of the county department of social services, with the exception that one member will be appointed upon the recommendation of a local law enforcement agency, and one member shall be assigned by that county's juvenile court.

The intent of the bill is to have established at least one multidisciplinary assessment unit in each county or group of contiguous counties. If a minimum number of children (as yet undetermined) from a county are being placed with the county department by the court for residential treatment, the establishment of an assessment unit in that county would be required of the director of the county department.

Alternatives to Nursing Home Care

Testimony from representatives of the U.S. Department of Health, Education, and Welfare indicated that the federal government is encouraging the development of alternatives to nursing home care.

Bill 53 -- Concerning Alternatives to Long-term Nursing Home Care for Older Persons and Relating to Appropriations for Provision of Such Services

The intent of Bill 53 is to develop pilot projects in each of the 63 counties to determine alternatives to long-term nursing home care by providing in-home health care and social services to persons 55 years of age or older. Medicaid funds will be sought to partially fund the program.

Administration. The program will be administered by the Department of Social Services, in conjunction with a Commission on Home Care Services which will be located in each county. The board of county commissioners in each county will appoint the members of each Commission on Home Care Services. Members of each commission will receive reimbursement for the expenses incurred in the performance of their duties.

Home Care Services. Home care services are defined to include services provided by home care services agencies, home health aid services, personal care services, homemaker services, and housekeeper or chore services.

Duties of the Commissions on Home Care Services. The duties of each of the 63 commissions will be to:

(a) Review all applications for nursing home placement and determine eligibility for alternative care;

(b) Advise the board of county commissioners on all aspects of home care services, advise in the review and coordination of efforts among agencies to develop home care services, and make appropriate recommendations to the board of county commissioners concerning home care services;

(c) Prepare plans for the delivery of home care services and submit such plans to the board of county commissioners;

(d) Establish requirements for a uniform statewide system of reports and audits relating to the quality of services provided and their utilization and costs;

(e) Establish schedules of rates, payments, reimbursements, grants, and other charges for nursing homes and home care services;

(f) Establish standards and procedures relating to certificates of approval and authorization to provide long-term home health care programs;

(g) Adopt uniform standards for quality of care and services to be provided by certified home health agencies and providers of long-term home health care programs;

(h) Establish minimum levels of staffing, taking into consideration the size of the agency or provider of a long-term home health care program, the type of care and service provided, and the special needs of the older persons served;

(i) Establish standards and procedures relating to contractual arrangements between home care services agencies;

(j) Establish requirements for uniform review of the appropriate utilization of services; and

(k) Set minimum qualifications and standards of training for personnel.

Allocation and administration of funds. All Medicaid funds appropriated in Colorado for nursing home care will be divided by the Department of Social Services among the 63 counties on a per capita basis, to be utilized by the counties for nursing homes or alternatives to nursing homes as each county determines. Administrative costs will not exceed ten percent of the total appropriation.

Community Mental Health Centers

Currently, Medicaid reimbursement for community mental health centers is restricted to services provided under the direct supervision of a physician. The mental health center is not considered a provider in its own right and is only reimbursed in the name and under the license number of a physician. As a result, the additional services provided by community mental health centers are not funded under Colorado's Medicaid plan.

Testimony indicated that Medicaid is the major funding source for mental health services in a number of other states and that while Colorado's Medicaid reimbursement for community mental health centers has decreased from approximately $600,000 to an estimated $400,000 over the last three to four years, the rate of reimbursement in other states has increased.

Bill 52 -- Concerning Mental Health Centers and Clinics

Bill 52 will expand the state's current Medicaid program to include all services provided by community mental health centers and clinics and will transfer the licensure authority from the Department of Health to the Department of Institutions.

Medicaid reimbursement. Bill 52 will expand the state Medicaid program to include "clinic services" in the list of basic services for the categorically needy. "Clinic services" are defined to mean community mental health centers.

Licensure authority. Bill 52 will transfer the licensure authority for maintenance of health standards for community mental health centers from the Department of Health to the Department of Institutions. In addition to the current responsibilities of the Department of Institutions for establishing standards and defining the services to be provided by community mental health centers, the Department of Institutions will also be responsible for issuing, refusing, or revoking licenses, based on prescribed minimum health standards established by rule of the department, a function currently being performed by the Department of Health.

Senior Citizens

Bill 55 -- Nursing Home Ombudsman Resolution

The committee recommends Bill 55, a joint resolution, which concerns the Nursing Home Ombudsman Program. The resolution encourages the continued independence of the ombudsman program relative to the proposed transfer of the program to the supervision of the State Department of Social Services.

In 1975, federal funds were made available to the Department of Social Services through the "Older Americans Act" for the creation of an ombudsman position. The department contracted with the Legal Aid Society of Metropolitan Denver to administer this model project, which has been renewed three years under their sponsorship.

Recently, the Division of Services for the Aging in the Department of Social Services submitted an application to the Administration on Aging in Washington to have the Nursing Home Ombudsman Program situated within the division. This proposed transfer was endorsed by the State Board of Social Services at its July, 1978, meeting.

A number of community and legal assistance organizations have opposed this transfer, primarily because of an apparent conflict of interest in housing the nursing home ombudsman, which has filed suits against nursing homes on behalf of residents, in the same department that has responsibility for certifying nursing homes for Medicaid.

This resolution is an expression of sentiment that it is necessary to have an autonomous ombudsman program, administered independently of the Division of Services for the Aging and the Department of Social Services. It is intended that the Colorado Commission on Aging will be responsible for determining the appropriate sponsorship of the Nursing Home Ombudsman Program, and that the Division of Services for the Aging will contract with the agent selected by the members of the Commission on Aging.

Bill 54 -- Joint Review Committee on Aging

In the course of the committee's review of federal, state, and local programs for senior citizens, the administrative capacity of the Division of Services for the Aging was frequently questioned. In part because the committee was primarily concerned with the identification of state programs for the elderly, a thorough review of the Division of Services for the Aging and an analysis of alternative administrative structures was not possible.

The committee recommends Bill 54, a joint resolution, which would establish a Joint Review Committee on Aging. This eleven-member committee will be comprised of members of the General Assembly as well as persons who are directly involved in providing services to elderly persons and elderly persons themselves.

This committee will meet concurrently with the General Assembly and will report its findings on or before March 15, 1979, to the Senate and House Committees on Health, Environment, Welfare, and Institutions.

The Joint Review Committee on Aging will examine the preliminary findings of the interim committee and submit recommendations for an appropriate administrative structure to coordinate and administer Colorado's programs for the elderly. In addition, the committee will review the statutory duties of the Commission on Aging. The March 15, 1979, deadline will enable the General Assembly to consider the recommendations of the Joint Review Committee on Aging during the 1979 session.

Members of the committee will receive no compensation. Staff services will be provided by the Legislative Council.

BACKGROUND REPORT

Medically Indigent

History of Colorado's Medically Indigent Program

Colorado's medically indigent program began in fiscal year 1974 as a line item in the long appropriations bill. Originally, the program was intended to provide financial assistance to Denver General Hospital to offset the substantial costs incurred by Denver taxpayers in providing health care services to a large indigent population which emanated from other areas of the state as well as from Denver itself. The program was designed primarily to subsidize certain hospitals that care for a large number of indigent patients. While at first blush the program appears to be a medical program, in reality the impetus for the program did not come from an overriding concern for the medical needs of the poor, but resulted from a political decision to provide relief to Denver General Hospital for its services to non-Denver indigent patients. Since its inception, the program has been administered by the Department of Social Services.

The scope of the program was expanded in fiscal year 1975 to include public hospitals and health centers located throughout the state, and thirteen hospitals agreed to participate in the program in that year. Since 1975, the number of hospitals has decreased to seven in 1978 as the available dollars under the program stabilized and health care costs borne by the participating hospitals continued to escalate.

For fiscal year 1979, eligibility for the program has once more been expanded to include private non-profit hospitals as well as related physician services.

Table I displays the funding for the program since FY 1974-75 and the number of participating hospitals. The distribution of the hospitals covers the central and southern two-thirds of the state, with the northern one-third of the state totally uncovered by participating hospitals.

TABLE I

Fiscal Year	Program Appropriation	Reimbursement to Participating Hospitals	
1974-75	$11,950,000	Denver General Hospital.....	$7,204,000
		Colorado Springs Memorial.....	168,000
		Prowers Medical Center.....	30,000
		Delta Memorial.....	26,000
		LaPlata Community.....	26,000
		Huerfano Memorial.....	16,000
		Aspen Valley.....	14,000
		Walsh District.....	14,000
		Clagett Memorial.....	7,000
		Salida City.....	6,000
		Memorial, Craig.....	2,000
		McNamara Memorial.....	1,000
		Conejos County.....	500
1975-76	$10,000,000	Denver General Hospital.....	8,509,000
		Colorado Springs Memorial.....	348,000
		Montrose Memorial.....	31,000
		Walsh District Hospital.....	30,000
		Delta Memorial Hospital.....	23,000
		Huerfano Memorial.....	23,000
		Aspen Valley Hospital.....	17,000
		Prowers Medical Center.....	2,000
1976-77	$ 9,576,000	Denver General Hospital.....	9,063,000
		Colorado Springs Memorial.....	602,000
		Walsh District Hospital.....	36,000
		Montrose Memorial Hospital.....	25,000
		Gunnison Public Hospital.....	5,000
1977-78	$ 9,069,453	Denver General Hospital.....	8,559,000
		Colorado Springs Memorial.....	443,000
		Walsh District Hospital.....	52,000
		Montrose Memorial.....	16,000
1978-79	$10,000,000	Denver General Hospital	
		Colorado Springs Memorial	
		Walsh District	
		St. Mary's - Grand Junction	
		Children's Hospital - Denver	
		Valley View - Glenwood	
		Southwest Memorial - Cortez (Montezuma County)	

Description of Current Program

The 1978 long appropriations bill provides $10,000,000 for the state's medically indigent program. The provisions of the long appropriations bill (footnote 105 and 105a) are as follows:

> Department of Social Services, Special Purpose Welfare Programs, Hospitals and Health Centers owned and operated by municipalities, counties, and hospital districts and private and nonprofit hospitals, Care of Indigent Patients -- Reimbursements provided by this appropriation shall be for all eligible billings made within 60 days following release for inpatient care or outpatient services rendered, exclusive of federal reimbursements, and less 3 percent of all hospital and center operating expenditures. Each hospital shall utilize the Colorado General Hospital's ability-to-pay fee schedule that is in effect for the 1978-79 fiscal year. In addition, each hospital shall provide to the Department of Social Services the data required by and submitted to the Hospital Rate Review Commission and a statement of county of residence of clients served.
>
> The Department of Social Services shall use $100,000 of these funds or so much thereof as may be necessary to pay, at the 1978-79 established Medicaid rate, licensed physicians who are not otherwise paid for services rendered to indigent patients in participating hospitals and health centers. Payment shall be distributed on a per capita basis through participating hospitals, excluding Denver General Hospital, unless these funds are distributed.

The significant aspects of the program are:

Indigent patient. "Indigent patients" are individuals or families who are residents of Colorado whose income falls within the parameters set forth in the Colorado General Hospital Inpatient and Outpatient Ability-to-Pay Scale, effective July 1, 1978, and who are not eligible under the federally assisted programs of Medicare (Title XVIII), Medicaid (Title XIX), and CHAMPUS (an insurance program for military dependents), or legally entitled to medical benefits under third-party coverage (i.e., commercial insurance, Workmen's Compensation, etc.), but whose income is insufficient to pay for necessary medical care at hospitals and health centers; and who are confirmed to be eligible by the Department of Social Services.

The ability-to-pay scale is designed to offer services to low-income persons, with the amount of financial assistance dependent upon the amount of the patient's resources and size of the family. A deductible is required for inpatient services, with outpatient and

physician services provided on a co-payment basis. The dollar amount of the deductible and co-payment are specified in Colorado General's ability-to-pay scale.

Eligibility of hospitals and health centers. Any hospital or health center, except state-owned hospitals, may participate in the program providing the participating provider's expenditures for indigent care exceeds three percent of the facility's gross operating expenditures, after the deduction of all federal reimbursement from all sources, including grants.

Reimbursement. Reimbursement for inpatient and outpatient care provided by participating facilities on behalf of indigent patients cannot exceed charges for similar care and indigency at Colorado General Hospital or actual charges, whichever is less.

Funds are distributed to participating hospitals under a "global budgeting" scheme, whereby all medically indigent patients can potentially receive these services. The hospitals are required to make their own determination of the eligibility of each patient. This procedure has resulted in decreased administrative costs to the program, as the Division of Medical Assistance must only process the claims they receive, rather than determine eligibility on claims. In the past, the division contracted with Blue Cross/Blue Shield to verify individual claims made for state medically indigent reimbursement, this service costing $500,000 annually.

The total dollar amount of all claims for medically indigent reimbursement is about twice the amount of state funds available, so reimbursement payments cover only about 50 percent of the costs for medically indigent services incurred by participating hospitals.

Audit requirements. Each eligible provider is responsible for the execution of an medically indigent program audit of indigent services provided during the period July 1, 1978, through June 30, 1979. Each eligible provider is responsible for the incurred cost of such an audit and it must be conducted by an independent audit agency contracted by the participating provider.

Financial Support for Medical Care for the Indigent

The committee's study directive, in part, concerned the need to analyze those health programs and services that are provided in the state for the medically indigent. An initial step in addressing this charge was the development of an estimate of the total amount of funds currently being spent for medical care for the indigent, and the sources of such support.

Most state-funded programs for the medically indigent are designed to provide inpatient and outpatient hospital care, and information on this support is more readily available than is information on that support which is made available by local governments or

the hospitals themselves. For these latter two sources of support, surveys were conducted by the Legislative Council staff.

Current dollar volume of charitable care being provided through hospitals in Colorado. From information currently available, it was estimated that $48,385,494 is currently being spent to provide services to the medically indigent in Colorado. This figure includes the total dollar value of uncompensated services, i.e., charitable care, provided by hospitals under the provisions of the Hill-Burton Act. The Legislative Council staff's review of the Hill-Burton data, as reported to the Colorado Department of Health, indicates that approximately $24,325,000 is being spent by Hill-Burton hospitals for charity care. This represents 50 percent of the hospitals in Colorado and approximately 80 percent of the beds.

The 1978 long appropriations bill provided $10,000,000 for care of indigent patients in hospitals and health centers owned and operated by municipalities, counties, hospital districts, and private and non-profit hospitals with $100,000 earmarked for related physician services. Footnote 43 appropriates $14,060,494 for the medically indigent at Colorado General Hospital. The $48,385,494 figure represents the total of the Hill-Burton obligation and the state general fund appropriations.

Surveys of counties and Colorado hospitals for provision of medically indigent services. In response to the committee's study directive to examine the extent of medically indigent services financed and provided by local governments and by hospitals in the state, two separate surveys were conducted to provide information on these issues:

a. County expenditures for medically indigent. This survey of Colorado counties was prepared by the Legislative Council staff with the cooperation of Colorado Counties, Inc. Its purpose was to identify the amount of county property tax support being provided for indigent medical care.

Survey forms were sent to the chairman of each Board of County Commissioners and to county financial officers. Data was requested, by fund category, for the counties' 1977 calendar year expenditures.

Although the response from the counties was incomplete, the data obtained indicates that most county expenditures for medically indigent services are in "General Assistance" within the Social Services Fund, and in "Public Health Programs" within the General Fund (or Revenue Sharing Fund). Some county expenditures were reported for ambulance services, and for health care for persons in county jails (See Table II).

TABLE II

CY 77 County Expenditures for Medically Indigent

	General Assistance	Public Health Services	County Jail 2/	Ambulance Service
Adams	$ 4,986	$ 44,666	$	$
Alamosa	None	11,325	1,371	
Arapahoe	None	76,656	61,958	
Archuleta	883	6,673		
Baca	2,413			
Bent				
Boulder	130,353			
Chaffee	1,194			
Cheyenne	253			
Clear Creek				
Conejos	1,600	20,000		
Costilla	None	31,794		
Crowley	988	4,500		
Custer				
Delta				
Denver	98,431	935,920		
Dolores				
Douglas				
Eagle	None			
Elbert	488			
El Paso	82,526	386,307	50,000	
Fremont				
Garfield	167		333	
Gilpin	1,171	7,358		
Grand	190	4,007	50	
Gunnison	152			
Hinsdale		600		
Huerfano	5,022	36,000	1,000	5,407
Jackson	300			
Jefferson	4,000			
Kiowa	4,946	3,500	None	
Kit Carson	4,491			
Lake	80	20,156		
La Plata				
Larimer	11,215	109,403		
County MIP	43,031 1/(RS)			
Las Animas	4,500	13,500		
Lincoln				
Logan	2,722	21,233	131	
Mesa	16,619		4,530	
Mineral	None	None		

	General Assistance	Public Health Services	County Jail 2/	Ambulance Service
Moffat	$ 403	$ 3,060	$ 1,933	$
Montezuma	537	11,000	877	
Montrose	683	14,714		
Morgan	439	22,645		5,900
Otero				
Ouray				
Park	None			
Phillips	3,657	4,653	in Gen. Assist.	
Pitkin				
Prowers				
Pueblo	73,700	20,996	37,396	
Rio Blanco	318			
Rio Grande	59	13,260		
Routt	2,399	4,320	1,500	
Saguache	710	9,400		
San Juan	None			
San Miguel	10	5,324		
Sedgewick		3,835		
Summit	None	2,500		
Teller	3,133	6,110	600	
Washington	682	6,251	None	
Weld	39,726	163,302		
Yuma	3,867	9,623		
TOTAL	$ 553,544	$2,035,099	$ 161,679	$ 11,307

1/ Larimer County Department of Social Services operates a Medical Assistance Program providing the following services: physician services only for in-hospital services; office calls; prenatal and cost of delivery; and prescription drugs. Medicaid rates used except for delivery which is slightly higher. A sliding scale based on family size and net income is used to determine income.

2/ Medical expenditures for those in the county jail may be accounted in any of three areas - General Assistance, Public Health, or the Jail budget.

b. Survey of hospitals regarding the amount of "free care" provided. With the cooperation of the Colorado Hospital Association, a survey was conducted to obtain information on the extent of charitable medical care currently being provided by hospitals across the state. Survey forms were sent to county, special district, and private hospitals, with a response received from about 50 percent of the hospitals in the state. No state hospitals were included in the survey.

A summary of survey findings indicates that: all but 11 hospitals responding participate in the federal Hill-Burton program, which provides grant and loan assistance to hospitals which pledge to provide a certain amount of charitable care annually; and that a large number of hospitals regularly conduct patient interviews for ability-to-pay.

In commenting on the administration of the current medically indigent program, the concensus of opinion among hospitals was that: the medically indigent program needs statutory recognition; physician services and non-hospital providers need to be recognized for adequate financial reimbursement through the program; that the three percent free care obligation prevents many hospitals from participating; the requirement of a CPA audit within 90 days after the end of the state's program year is an expensive one; and that the mandated use of the Colorado General Hospital ability-to-pay scale is not applicable to many areas of the state (See Appendix A).

Patient Origin Studies

The bulk of the state general fund appropriation for the care of the medically indigent is received by Denver General Hospital and Colorado General Hospital. Denver General Hospital historically has received from 85 to 90 percent of the approximate $10 million annual appropriation for the state medically indigent program. For fiscal year 1978-79, the line item appropriation to Colorado General Hospital for the care and treatment of the medically indigent is approximately $14 million.

Partly in response to the committee's study directive to examine the role of Colorado General Hospital and other public hospitals in the provision of services to the medically indigent, Denver General Hospital and Colorado General Hospital conducted a patient origin study for the medically indigent patients which were admitted to their respective hospital. This study entailed a detailed analysis of the county of residence of each of the patients, the diagnosis of the patients, and their length of stay. The major findings of these two studies, as they were reported to the committee, follow. (See Exhibit A and Exhibit B).

Report to the HEWI Committee
City & County of Denver
Medically Indigent Care
September 27, 1978

I. Introduction

The following report was extracted from computerized patient data for Health and Hospital activity during calendar year 1977. Because of new programming techniques we believe this information is internally consistent. We cannot, however, be certain that it reflects 100% of all Department activities during that year.

II. Inpatient Care - 1977

A. Admissions

	#	%
M I Admissions	7,656	39.2
Other Admissions	11,899	60.8
Total Admissions	19,555	100.0

B. Patient Days

M I	41,519	39.8
Other	62,817	60.2
Total	104,336	100.0

C. Average Length of Stay

M I - 5.4 days
Other - 5.3 days
Total - 5.3 days

D. Most Frequent Diagnoses - Medically Indigent

The 50 most frequent primary diagnoses were rank ordered. These 50 accounted for 5,174 or 67.6% of the indigent admissions. The top two diagnoses, uncomplicated deliveries and alcoholism, accounted for 33% of all M.I. admissions.

By combining certain related categories we can assess the impact of perinatal cases.

Rank Order	Diagnosis	#	%
1	Delivery - normal	1,745	22.8
5	Abortion/Legal ind.	133	1.7
6/23	Complications of Pregnancy	160	2.1
28	Conditions of Fetus/Newborn	38	.5
32	Single born/premature	32	.4
47	Delivery/Complications	23	.3
	Pregnancy related	2,131	27.8%

EXHIBIT A

D. (contd.)

The 1,768 normal and complicated deliveries account for 68% of the total 2,601 DGH deliveries recorded by the State Health Department. This is significantly higher than the 40% M.I. ratio to total admissions. We can now estimate that of the 622 deliveries from residents of other counties, at least 423 were most likely medically indigent

In what may be a unique Denver General role, admissions for serious psycho/social/emotional disturbances also account for a significant amount of inpatient care.

Rank Order	Diagnosis	#	%
2	Alcoholism	783	10.2%
3	Alcoholism Psychosis	250	3.3
4	Schizophrenia	206	2.7
11	Personality Disorders	74	1.0
15	Neuroses	64	.8
44	Drug Dependence	24	.3
50	Adverse Effects-Psycho-theropeutics	23	.3
	Psycho-Social	1,424	18.6%

In 1977, we recorded 1,988 admissions in these areas. The 1,424 M.I. admissions equate to 71.6% of the total. Obviously persons with these dysfunctions tend to be among the very poor.

The remaining 36 listed diagnoses run the gamut of medical care, and, we assume, so do the remaining 2,482 admissions which did not make the "top 50".

E. Inpatient Care for Out-of-Denver Residents - Medically Indigent

In 1977 we recorded 1,515 medically indigent admissions of persons who resided outside the City and County of Denver. These 1,515 admissions amount to 19.8% of all M.I. admissions. The bulk came from the large counties surrounding Denver.

County	#	% of Out-of-Denver Admissions
Jefferson	929	61.3%
Adams	209	13.8
Arapahoe	164	10.8
Boulder	94	6.2
All Others	119	7.9
Total	1,515	100.0%

III. Outpatient Care

Unfortunately we do not yet have directly comparable data to relate M.I. outpatient care with all outpatient care. We can, however discuss the numbers and levels of M.I. care and the most frequent diagnoses.

A. Statistics

Number of Patients - 46,937
Number of Outpatient Visits - 246,937
Average visits/patient - 5.26

B. Most Frequent Diagnoses

The 50 most frequent diagnoses account for 217,176 visits, or 87.9% of all M.I. visits. The top five equate to 36.9% of the M.I. visits. They are:

Rank	Diagnosis	#	%
1	Disease/Condition of Teeth	23,529	9.5%
2	Medical/Special Exam	20,406	8.3
3	Prenatal Care	17,658	7.2
4	Alcoholism	15,873	6.4
5	Acute Upper Respiratory Infection (colds)	13,487	5.9
	Top Five	90,953	36.9%

Medical conditions relating to pregnancy and psyco/social diseases again are major areas of concerns. In fact, alcoholism, neuroses, schizophrenia, and personality disorders together account for 11.7% of the M.I. outpatient visits. Considering the chronic nature of these ailments, this should be expected. The sixth most frequent diagnosis was "Person without complaint or illness" and accounted for 4% of the visits. One might speculate that such persons are actually seeking social support vs. actual medical care and should perhaps be viewed with the psycho/social ailments.

The most frequent diagnosis relates to the already established need for dental care among the poor. We assume that medical exams (#2) are primarily preventative, one of the major goals of the outpatient system. It probably surprises no one that the common cold brought a significant number of visits.

IV. Cost of Care - Medically Indigent

	Inpatient	Outpatient	Total
Total billed	$10,291,741	$9,342,308	$19,634,049
Billed to patients	$ 1,315,142	$1,266,098	$ 2,581,241
Average % pay	12.8%	13.6%	13.1%
Collected from patients			$ 283,936*
% collected/billed			11.0%
Uncollected			$ 2,297,730
Billed to State M.I.			$17,052,809
Collected from State			8,770,000**
% Collected - State			51.4%
Uncollected			8,282,805

The City and County of Denver expended approximately $10.6 million in 1977 of local tax revenues to care for the medically indigent described in this report. In addition, the city share of the public health nursing expenditures was $1,169,900. Another $98,431 was spent by the Department of Social Services for general medical assistance.

*Estimates based on 11% rate - not in computer run.

**1/2 of 76/77 allocation + 1/2 of 77/78 allocation - not in computer run.

Department of Health and Hospitals

Medically Indigent Data

City Fiscal Period - January - December 1977

Inpatient Care

Number of Patients	7,656	
Number of Patient Days	41,519	
Average Length of Stay	5.42 Days	
Total Billed MI	8,976,599	
Total Billed Pat/Pay	1,315,142	
Total Billed	$10,291,741	
Average Cost Per Incident of Care		$1,344.27
Average Cost Per Patient Day		$ 247.88

50 Most Common Diagnosis

Diagnosis	Number of Cases
Delivery - Without Complication	1,745
Alcoholism	783
Alcoholic Psychosis	250
Schizophrenia	206
Abortion Induced for other Legal Indications	133
Other Complications of Pregnancy	114
Certain Symptoms - Nervous System	110
Fracture of Face Bones	95
Diseases of Paramelrium and Pelvic Peritoneum	89
Diabetes Mellitus	82
Personality Disorders	74
Other Diseases of Respiratory System	72
Pneumonia, Unspecified	70
Cirrhosis of Liver	65
Neuroses	64
Inguinal Hernia Without Mention of Obstruction	64
Intercranial Injury	61
Pre-Eclampsia, Eclampsia and Toxemia	52
Systoms Referable to Respiratory System	50
Systoms Referable to Abdomen. Lower Gast. Tract	50
Essential Benign Hypertension	49

Medically Indigent Data

Diagnosis	Number of Cases
Acute Appendicitis	46
Other Complications of Pregnancy	46
Other Multiple Open Wounds	44
Fracture of Ankle	43
Other Diseases of Intestines	41
Asthma	38
Other Conditions of Fetus or Newborn	38
Otitis Media Without Mention of Mastoiditis	34
Chronic Ischemic Heart Disease	34
Open Wound Finger(s)	33
Single Born, Premature	32
Open Wound of Chest	31
Diseases of Pancreas	30
Other and Unspecified Lacerations of Head	30
Other General Symptoms	28
Fracture of Tibia and Fibula	28
Hyperemesis Grovidarum	27
Fracture of Base of Skull	27
Fracture of Face Bones	27
Diarrheal Disease	25
Pneumococcal Pneumonia	25
Open Wound of Elbow, Forearm and Wrist	25
Drug Dependence	24
Acute Myocardial Infarction	24
Other Diseases of Urinary Tract	24
Delivery With Other Complications	23
Sprains and Strains of Knee and Leg	23
Contusion of Trunk	23
Adverse Effect of Psychotherapeutics	23

Outpatient Care

Number of Patients	46,937	
Number of Outpatient Visits	246,937	
Average Visits Per Patient	5.26	
Total Billed MI	8,076,210	
Total Billed Pat/Pay	1,266,098	
Total Billed	$9,342,308	
Average Cost Per Visit		$37.83

Medically Indigent Data

50 Most Common Diagnosis

Diagnosis	Number of Visits
Other Diseases and Conditions of Teeth	23,529
Medical or Special Examination	20,406
Prenatal Care	17,658
Alcoholism	15,873
Acute Upper Respiratory Infection	13,487
Person Without Complaint or Illness	9,841
Otitis Media Without Mention of Mastoiditis	8,077
Neuroses	5,859
Diseases of Hard Tissues of Teeth	5,688
Essential Benign Hypertension	5,619
Observation, Without Need for Further Medical Attention	5,118
Schizophrenia	4,581
Medical and Surgical Aftercare	4,369
Symptoms Referable to Abdomen and Lower Gast Tract	3,863
Acute Pharyngitis	3,820
Periodontal Diseases	3,738
Other and Unspecified Laceration of Head	3,391
Diarrheal	2,944
Diabetes Mellitus	2,928
Other Viral Diseases	2,831
Personality Disorders	2,675
Repractive Errors	2,643
Disorders of Menstruation	2,568
Symptoms Referable to Limbs and Joints	2,564
Other Eczema and Dermatities	2,513
Symptoms Referable to Respiratory System	2,501
Streptococcal Sore Throat and Scarlet Fever	2,477
Headache	2,470
Certain Symptoms Referable to Nervous System	2,288
Other Diseases of Urinary Tract	1,939
Asthma	1,921
Open Wound of Finger(s)	1,872
Diseases of Sebaceous Glands	1,801
Infective Diseases of Uterus	1,787
Conjunctivitis and Ophthalmia	1,745
Superficial Injury of Face, Neck and Scalp	1,598
Transient Situational Disturbances	1,519
Other Diseases of Ear and Mastoid	1,502
Acute Tonsillitus	1,481

- Medically Indigent Data

Diagnosis	Number of Visits
Medical and Surgical Aftercare	1,406
Obesity Not Specified as of Endocrine Origin	1,401
Vertebrogenic Pain Syndrome	1,382
Bronchitis, Unqualified	1,363
Vertebrogenic Pain Syndrome	1,324
Osteoarthritis and Allied Conditions	1,280
Hay Fever	1,231
Other General Symptoms	1,154
Sprains and Strains of Ankle and Foot	1,088
Gonococcal Infections	1,049
Moniliasis	1,014

UNIVERSITY OF COLORADO MEDICAL CENTER
COLORADO GENERAL HOSPITAL

Inpatient Origin Study
January 1, 1977 - December 31, 1977

The attached reports summarize data on the inpatient population at Colorado General Hospital from January 1, through December 31, 1977. The data includes: the total number of patient days by county and the average length of stay (LOS) by county for indigent (rated) and non-indigent (full-fee) patients. The inpatient population is also divided into four categories: 1) Denver County, 2) Other Denver Metro Counties, 3) All Other Colorado Counties, and 4) Out of State patients.

The purpose of this study is to determine the origin of patients admitted to CGH during 1977, and to analyze the provision of health care services by C.G.H. to the medically indigent population of Colorado.

The data can be summarized as follows:

ANALYSIS OF PATIENT ADMISSIONS

1. 27.5% of the patients (5074 of 18,464) admitted to C.G.H. during 1977 originated from Denver County. Of these, 35.1% (1783 patients) were rated as either totally or partially indigent.
2. 40.7% of the total inpatient population (7,489 of 18,464) was from the other four Denver metropolitan area counties. Of these, 48.6% (3638 patients) were categorized as indigent.
3. A total of 12,563 patients originated from the five-county Denver metro area, representing 68.0% of all patients admitted to C.G.H. during 1977.

EXHIBIT B

4. 23.6% of the inpatients (4,377 of 18,464) originated from Colorado counties outside of the Denver metro area. Of these, 36.7% (1606 patients) were medically indigent.
5. 8.2% of the patients (1,524 of 18,464) came from outside of Colorado. Of these, only 10 patients (0.7%) were medically indigent representing 0.7% of the out-of-state patients admitted to C.G.H. in 1977.

It may be concluded from this data that the majority of patients admitted to Colorado General Hospital in 1977 originated from the Denver metro five-county area. Of the more than 18,000 inpatients at C.G.H. in 1977, 7,037 or 38.1% were medically indigent.

The greatest number of patients originating from areas outside the Denver metro area were from Boulder County (4.2%) and Weld County (4.1%). Of the 776 patients from Boulder County, 45.6% were medically indigent, while of the 748 patients from Weld County, 61.2% were indigent.

ANALYSIS OF PATIENT DAYS

1. Patients from Denver County utilized 25.3% of the 120,110 inpatient days at C.G.H. during 1977. Of these 30,332 days, 26.5% were in the medically indigent category.
2. Patients from the four other Denver metro counties utilized 33.0% of the total inpatient days. Of these 39,674 days, 42.1% represented indigent patients.
3. Patients from the five-county Denver metro area utilized 58.3% of the inpatient days at C.G.H. in 1977. Of these 70,006 days utilized by Denver metro area residents, 24,726 or 35.3% represented the indigent population.

4. Patients from all other Colorado Counties, outside of the five county Denver metro area, utilized 28.1% of the inpatient days at C.G.H. Of these 34,054 days, 26.4% were representative of the indigent population.
5. Out-of-state patients utilized 13.4% of the total inpatient days at C.G.H. in 1977. Of these 16,050 days, only 79 or 0.5% were representative of the medically indigent.

Therefore, of the greater than 120,000 inpatient days at C.G.H. in 1977, 28.2% (33,813 days) were representative of medically indigent patients. Comparing these figures with the 38.1% rate of indigent admissions to C.G.H. in 1977, we can see that the medically indigent population experiences a shorter length of stay. This implies that less complex care was being sought by the medically indigent group coming to C.G.H.

LENGTH OF STAY ANALYSIS

1. The average length of stay (LOS) for medically indigent patients from Denver county was 4.5 days compared with 6.8 days for full-fee patients.
2. The average length of stay for indigent patients from the other four Denver metro counties was 4.6 days compared with 6.0 days for full-fee patients.
3. Indigent patients from Colorado counties outside of the Denver metro area had an average length of stay of 5.6 days compared with 9.0 days for the full-fee patient population.
4. The 10 out-of-state indigent patients had an average length of stay of 7.9 days compared with 10.5 days for full-fee patients.

The average length of stay for all medically indigent patients admitted to C.G.H. in 1977 was 4.8 days compared with 7.6 days for full-fee patients. This data indicates, once again, that less complex care is being sought by the medically indigent population utilizing C.G.H. as compared with the full-fee population.

In addition, patients coming to C.G.H. from counties outside of the Denver metro area have a significantly longer LOS than those coming from within the region, indicating a greater complexity of care being sought by these patients.

NOTE: The following schedules (Attachments II-B and II-C) pertain to Colorado General Hospital inpatient caseload by county of origin for calendar year 1977. Attachment II-C portrays indigent caseload by county of origin for the same period. It should be noted that the "rated patient" data on Attachment II-C only refers to indigent patients who have no third party coverage. Indigent patients with third party coverage are intially classified by insurance source until such time as these funds are received. At this time, the patient's indigency rating is applied to the remaining balance.

UNIVERSITY OF COLORADO MEDICAL CENTER
Colorado General Hospital
Inpatient Origin Study
January 1, 1977 - December 31, 1977

The attached reports provide a diagnostic categorization of the inpatient population at Colorado General Hospital from January 1, 1977, through December 31, 1977. The most frequently occurring diagnoses are presented for indigent (rated) and non-indigent (full-fee) patients originating from twelve Colorado Counties: Adams, Arapahoe, Boulder, Clear Creek, Denver, Douglas, El Paso, Jefferson, Larimer, Morgan, Prowers and Weld. Only these counties had 45 or more medically indigent patients admitted to Colorado General Hospital during the 1977 calendar year. Data by diagnosis is available for the remaining Colorado counties, but because of the small number of indigent patients originating from these areas, diagnostic categorization was not done.

In 11 of the 12 counties included in the report, "Newborns"and "Delivery" were the two most frequent diagnostic categories for the indigent patients admitted to CGH during 1977. Only 6 of the 12 non-indigent populations had "Newborns" and "Delivery" as the two most frequently occurring diagnoses.

It is interesting to note that in 6 of the 12 non-indigent inpatient populations, "Signs; symptoms and ill-defined conditions" ranks as the first or second most frequently occurring diagnostic category. However, none of the 12 county indigent populations display this diagnosis in the first or second most frequent category.

In 9 of the 12 county indigent populations, "Maternal Care" ranks in the 10 most frequently occurring diagnoses. However, in the 12 non-indigent county populations, "Maternal Care" occurs as a diagnosis in only one county.

"Abortion" ranks as one of the most frequent diagnoses in 9 of the 12 county indigent populations. Interestingly, only 3 of the 12 county non-indigent populations experience "Abortion" as a frequent diagnosis. In 4 of the 12 indigent population groups, "Complications of Pregnancy" occurs as a frequent diagnostic category. This diagnosis does not occur in any of the non-indigent population groups as a frequent diagnosis.

"Diseases of the Respiratory System" is a frequent diagnosis in 9 of the 12 indigent population groups and 10 of the 12 non-indigent groups. In 8 of the 12 indigent groups, "Fractures, dislocations and sprains" occurred as a frequent diagnosis. In only 3 of the 12 non-indigent population groups was this true.

In 3 of the 12 indigent population groups admitted to Colorado General Hospital during 1977, "Diseases of the ~~ovary,~~ -fallopian tubes, parametrium, uterus and other female genital organs" occurred frequently. This same diagnostic category occurred with frequency in only 1 of the 12 non-indigent county populations included in this report.

In 9 of the 12 non-indigent population groups, "Primary and secondary malignant neoplasms" and "Primary neoplasms of lymphatic and hematopoietic tissues" occurred with frequency. However, these two diagnostic categories were common in only 3 of the 12 county indigent population groups included in the study.

Definition of the Problem

In an effort to define the problem with the existing system for provision of medical care to indigent persons in Colorado, and in an attempt to identify some of the basic policy decisions which the committee would have to confront before a new system could be designed to manage the problem, six fundamental questions were submitted to the following organizations for their response: Colorado Hospital Association, Colorado Health Research Coalition, Colorado Medical Society, Colorado Social Legislation Committee, Colorado General Hospital, Colorado Department of Health, Colorado Department of Social Services, City of Colorado Springs, and the City and County of Denver.

The questions and the text of the responses are included in this section of the report.

> QUESTION NO. 1: SHOULD THE STATE ASSUME ANY FURTHER RESPONSIBILITY FOR PROVIDING FINANCIAL SUPPORT TO PAY FOR NECESSARY MEDICAL CARE IN HOSPITALS (AND RELATED PHYSICIAN CARE) FOR PEOPLE WHO CANNOT AFFORD TO PAY FOR THE MEDICAL CARE? WHAT, IF ANY, SHOULD BE THE FINANCIAL PARTICIPATION ON THE PART OF LOCAL GOVERNMENTS?

Colorado Hospital Association

Only after the following questions are answered can we begin to respond to the question of greater participation by the state. We are not by-passing the question but think more information is necessary before we can respond in a responsible manner.

a) What is the definition of "medically indigent" going to be? Right now it seems the definition is molded to meet an individual program's need, and with multiple programs we have different definitions for the same term.

b) What degree of care is to be provided (total care, emergency care, major medical care, etc.)?

c) How much will it cost and to what degree is the total state budget dedicated to health care of this form?

Colorado Medical Society

a) The medically indigent need to be cared for, but they need to be provided only with needed medical care.

b) A program is needed that will minimize administrative costs.

c) There needs to be the use of the least expensive vehicle to

provide care (i.e., private physician's office), practice pattern must change on length of stay.

d) The authorized program can't be another "Medicaid":

Physicians can't afford to have 25-30 percent of their practice as Medicaid patients, and hospitals can't afford more than 10 percent Medicaid patients. Local government needs to be involved in the program, which also implies local financial contributions.

Colorado Social Legislation Committee

It is the opinion of members of the Colorado Social Legislation Committee that federal, state, and local levels of government are to some degree responsible for providing necessary medical care for people who cannot afford to pay for such care. Before the state assumes further responsibility for providing financial support for such care, a careful study should be made of the availability of federal funds for various types of medical programs, for example, a medically needy program through which state dollars currently spent for the medically indigent would be matched dollar for dollar by federal funds to serve a population of aged, blind, and disabled persons who do not qualify for Medicaid funds. To the extent that state funding of programs insures state control and state responsibility for such programs, we are in favor of state financial support for programs for the medically indigent. However, several factors seem to point to the need for an objective investigation and consideration of the possibility of obtaining more federal support for programs for the medically indigent in this state.

a. The number of migratory farm workers who come to Colorado from other states to harvest the crops.

b. The expected increase in population, particularly on the Western Slope, when energy-related industries begin to attract workers from other states, as well as their families.

The Colorado Social Legislation Committee also recommends that the possibility be explored of obtaining federal subsidization for enrolling families and individuals classified in the working poor category in Health Maintenance Organization plans, particularly in the area of preventive medical care.

The Colorado Social Legislation Committee urges that an investigation be made of the possibility of including other health services for the medically indigent in models comparable to the structure set up for implementing denture legislation passed in the 1977 Session of the General Assembly and the parinatal legislation proposed in the 1978 Session.

Although, ideally, local governments should share in support of programs for the medically indigent, in practice they often are reluctant to do so, as testimony before the Senate HEWI Committee in the 1978 Session indicated. Since the preponderance of medically indigent persons apparently come from the most economically disadvantaged counties of the state which cannot pay for medical care, we suggest that the legislature discuss the possibility of requiring a system in which the local share of costs for the medically indigent would be equally shared by all counties in the state.

Colorado General Hospital

The state should consider additional responsibility in the following areas:

a) MI Program support to Faculty Practice Fund;

b) $1.9 million requested in 1978-79 budget, but not funded;

c) Full funding of medical services provided under Medicaid (50 percent federal match);

d) MI Program expansion should be focused on:
   -- medical services by diagnosis (e.g., perinatal)
   -- geographical accessibility to MI services
   -- full reimbursement of hospital expenses
   -- catastrophic episodes that might prove ruinous to persons not ordinarily eligible for MI support

Colorado Department of Health

We believe the state should develop a system of financial coverage and assistance for needed health care services for Colorado's medically indigent population. The current program for the medically indigent is limited to payments for hospital care in certain facilities, and some physician services related to hospital care. We believe that the state should:

a. Examine the health and medical needs of the medically indigent;

b. Determine a set of priority services to be covered;

c. Establish geographic accessibility statewide; and

d. Devise payment mechanisms (either through insurance or reimbursement programs) to assure that covered services are paid for.

While it is desirable that local governments contribute to the costs of such a program, the development of efficient, unduplicated,

streamlined administration probably requires a single central mechanism. Fragmentation of administration is costly and duplicative. It is particularly problematic in our mobile society, where people frequently move from county to county.

Local government participation in the costs of care, while optimally desirable, appears to be counter to today's trends of property tax relief and more state and federal income transfers.

Colorado Department of Social Services

In summary, we believe the state has a responsibility to assume a greater financial responsibility for medical care in hospitals. Participation by local governments would be far superior to the current method of financing the underfunded Medically Indigent Program if the problems of total participation by all local governments can be worked out. To continue to require the hospitals, through their own revenue resources, to pick up the underfunded program works a serious hardship upon either private paying patients, local governments, or people who provide charitable contributions.

City of Colorado Springs

The local task force that was organized to discuss this issue feels that payment for the medically indigent is primarily a state responsibility, both for physician and hospital care. The lack of full reimbursement may be somewhat eased with the additional funding made possible in the last legislative session, but there are unknowns, i.e., the impact of inclusion of the nonprofit private hospitals for reimbursement. However, we know that the inclusion of funds for physicians and the increased medically indigent funding still fall woefully short of meeting current charges. The private hospitals feel that the requirement that they provide three percent free care before they can enter the Medically Indigent Program is a real constraint for them.

A local government responsibility to share in these hospital costs is recognized by all counties in the state except El Paso County. However, that county does provide over $100,000 in support of public health and primary health care for the indigent.

City and County of Denver

In essence, state government must continue its existing role in the provision of health services, and increase its role in meeting the demands that it has helped to create. Recognizing the responsibility to conserve state dollars, we would encourage that the state's role be met through the provision of publicly-sponsored medical facilities.

Local government should be expected to participate in this pro-

gram because health, and/or its absence, adversely affects local economy through welfare contributions, utilization of local social institutions, etc. Local government's contribution should be either direct in the form of dollars committed to the state program, or indirect through the provision of direct services that meet state program objectives, but all counties should contribute equally on a per capita basis.

The increasing utilization of Denver's health facilities by residents of other counties speaks to the need for these counties to accept their share of this health program -- a program which maximizes use of public facilities for efficient economies of scale.

QUESTION NO. 2: WHAT ARE OR WHAT SHOULD BE THE MAJOR OBJECTIVES OF THE PRESENT MEDICALLY INDIGENT PROGRAM OR FOR AN EXPANSION OF A STATE MI PROGRAM?

Colorado Health Research Coalition

Attention should be directed to those people who inevitably "fall through the cracks":

a) Catastrophic illness to a person under age 65, such as a stroke which incapacitates, is an example. A comprehensive Medically Indigent Program would lessen the period of treatment if not eliminate it.

b) That segment of the population who are inadequate to compete in every day economic life and periodically are grossly in need of medical services.

Colorado Hospital Association

We are under the impression no one really knows what the current goal of the MI Program is beyond making money available for Denver General Hospital (this was originally a trade-off to Denver County by the suburban counties over the annexation battle of a few years back). Since, in our estimation, this was a political decision and not a health decision, we think the objectives of the Medically Indigent Program need to be defined by the legislature (i.e., political vs. health).

Colorado Medical Society

a) To provide quality care in local areas, as opposed to sending indigent patients to Colorado General Hospital.

b) To develop local programs with local controls: identification and screening of patients locally.

c) Local sliding scale to qualify persons for the program.

d) Free choice of physician.

Colorado Social Legislation Committee

a) The program should be truly statewide in scope. This would alleviate the situation which exists at the present time of requiring the medically indigent to travel many miles, sometimes at risk to their lives, in order to receive medical care.

b) The MI Program should include eligible hospitals in all parts of the state so that adequate primary care can be received at the local level.

c) Preventive programs and services which enable people to maintain their jobs should be favored whenever possible. Preventive services will eventually prove to be cost-saving for the state, e.g., perinatal care.

d) The legislature should investigate the possibility of passing enabling legislation for MI Programs to replace current footnote status in the state's annual budget.

e) The state should move toward a goal of adequate financing based on comprehensive planning rather than the present piece-meal approach.

f) Accentuate accountability; upgrade fraud prevention in the area of providers.

g) Disseminate information on and enforce posting of notices regarding the regulation that hospitals which have received Hill-Burton funds must spend three per cent of their income on care of the medically indigent.

h) Emphasis on group medical practice and especially pre-payment plans.

i) Emphasis on out-patient, out-of-hospital, and home health care.

j) Work with private organizations and educational agencies to provide health education including nutrition education in a more effective way.

k) Motivate and coordinate cooperation with private organizations and agencies in the area of volunteer recruitment in order to provide expertise and assistance with MI Programs.

l) The state should assume a more forceful role in encouraging the establishment of local mental health and health centers in

underserved areas. These would hopefully entice physicians who could take care of the health needs of the local population, including the medically indigent.

m) Investigate the possibility of requiring state-subsidized medical students to provide quality care for the medically indigent as a requirement of their training. Look at the possibility of state subsidization to allow medical personnel to remain in rural areas.

Colorado General Hospital

Services should be:

a) cost effective;

b) easily accessible;

c) for a broad range of medical services;

d) on a co-payment basis;

e) reimbursed to include physician services.

Colorado Department of Health

From the standpoint of the Department of Health, the objectives of any medically indigent health program should be:

a) To provide financial assistance for adequate primary and preventive health services to individuals in need of such, particularly certain populations such as mothers and children.

b) To assure availability and financial assistance for needed hospital care to persons unable to pay for all or part of the costs of such care.

c) To assure availability of primary care services for all medically needy children.

Colorado Department of Social Services

The principal objective of the program is and should be the expansion of the number and area of location of providers. At present, individuals in various sections of the state (i.e., wherein a participating hospital is not located) do not have equal access to the Medically Indigent Program. In order to avail themselves of the program, they frequently must travel great distances to reach a participating hospital, or forego totally the benefits of the Medically Indigent Program. Secondly, since many rural and frequently low cost

hospitals do not participate, the population migrates to Denver to utilize the services of a relatively higher cost Denver General Hospital. This presents an ineffective and inefficient health care provider system. Hence, the Department of Social Services believes that efforts to expand the number of participating hospitals, especially the geographic distribution of these hospitals, would be a significant benefit to the MI Program.

A secondary objective of the program should be to increase the budget allocated to physicians for services they provide in inpatient and outpatient hospital settings. The $100,000 allocated this year, we believe, will cover only a relatively small portion of the charges for these covered services which the physicians will generate. To encourage the medically indigent recipients to seek care in participating hospitals in local communities will require that local physicians support the program and admit these patients to the local hospital. Increased funding for physician services provided in the hospital will encourage such admission practices.

City of Colorado Springs

Having had only line item designation in the long bill has been counterproductive to establishing goals and objectives for health care for the medically indigent. A potpourri of categorial programs, both federal and state, without coordination of such things as target population, eligibility, and reimbursement has further fragmented efforts.

A major issue which fosters this fragmentation is that of preventive care vs. care during illnesses. These are not "either/or" alternatives, but do reflect where opinions may differ regarding the major objectives of MIP. Preventive care has the strong asset of being a very significant factor in cost containment, while care during illness by its very immediacy, and the high costs which may be involved, creates a crisis situation demanding funds in order to assure the continuing availability of those essential to the provision of services.

City and County of Denver

Any state-supported program directed at the medically indigent population should have as its objectives:

Priority 1: To provide physician and support services for urgent health needs.

Definitions:

Physical services -- Services provided by a physician, dentist, or by an appropriately qualified individual under the supervision of a physician.

Urgent -- As defined by the patient's perception of his problem.

Needs -- Judgment made by a professional, taking into consideration the patient's demands.

Support Services -- Those diagnostic and therapeutic services necessary for the physician to serve urgent health needs.

Priority 2: To provide cost-effective programs directed at preventing diseases resulting in disability.

Priority 3: To provide physician and support services for non-urgent and chronic health needs in which treatment will reverse, reduce, or prevent disability.

a) Physical

b) Mental-Social

Priority 4: To provide services that improve the existing quality of life.

A minimum program for fiscal year 1979-80 must be the maintenance of the present system which insures the availability of access to both acute and chronic health care. Although the services are not always convenient, they are always available. Close linkage between public and private institutions have been forged and should be maintained.

QUESTION NO. 3: IN YOUR ESTIMATION, WHAT SHOULD BE THE TARGET POPULATION FOR A MEDICALLY INDIGENT PROGRAM?

Colorado Health Research Coalition

There is a significant number of low-income senior citizens in Colorado. Lower income senior citizens, not qualified or using Medicaid, have substantial out-of-pocket medical expenses, averaging $571.00 per year. Some of the hardships for the low-income seniors not covered by Medicaid have been pointed out, however, it is not recommended that the committee consider the medical needs of the non-Medicaid population at the expense of the Medicaid population.

One age group that deserves considerable attention are persons between age 55 - 65 who are either disabled, unemployed, or unemployable. People who are defined as disabled by Social Security must wait over two years before receiving Medicare benefits. During this time the individual is in great need of medical insurance coverage which is often cost-prohibitive. If a person does obtain coverage

the waiting period for pre-existing illnesses is often six months to twelve months before coverage starts.

The committee should commit some of their time and resources to examining the medical needs of the low-income elderly who do not qualify for Medicaid. The state's elimination of the spenddown Medicaid program July 1, 1979 will not go unnoticed. The spenddown program was the only statewide medical service available to help this group. Because this policy change was just initiated, we have no data to indicate what repercussions might occur.

Colorado Hospital Association

The potential target population is almost unlimited. Since the "ability-to-pay scale" has been mandated into the current system, it would seem no one would be excluded because it has been established that as an individual's personal resources are diminished the state would assume a greater responsibility. We recognize that this system, carried to any extreme, would prove disastrous to the state's financial resources. As such, any medically indigent program would have to have a specific target group. Therefore, a program designed to supplement Medicare, Medicaid, and other social service type systems would seem to be in order.

Colorado Medical Society

The target population should include:

a) patients not eligible for other care; and

b) the working poor who can't afford treatment.

Colorado Social Legislation Committee

a) Perinatal care for women in the working poor category.
b) Aged, blind, disabled.
c) Mentally ill persons whose health needs are not being met.
d) The working poor.

Colorado General Hospital

a) Categorical programs (Perinatal, etc.).
b) Catastrophic illness.
c) All indigents, using an ability-to-pay rating.

Colorado Department of Health

The target population should be all individuals deemed to be medically indigent, i.e., persons unable to afford the full cost of medical care. The definitions of "medically indigent" will vary depending upon the cost of care received and its perceived desirability. In other words, there should be a differential eligibility system based upon:

a) cost of service;

b) ability of persons or family to pay a portion of the care;

c) desirability of service, i.e., prevention and primary care should be encouraged; and

d) ability to realistically collect a portion of the costs from the family.

Eligibility guidelines should be set in a way that encourages use of primary care and preventive services. We know that the current health behavior of the poor is usually the reverse of the optimal, i.e., the lower the family income, the less frequently primary and preventive care is sought. Poorer people tend to wait until their medical and health needs become acute before they seek care. Thus, when care is finally delivered, it is usually the most expensive, and ironically, the more preventable.

Colorado Department of Social Services

We believe, in general, that the target population for the current Medically Indigent Program is the appropriate population. Currently, the Medically Indigent Program serves those people who cannot afford private health insurance, who do not qualify for Medicaid, Medicare, or any other governmental health care program, and who have insufficient funds to pay for the care required. The criteria utilized to determine eligibility for the Medically Indigent Program relate only to the income and size of the family. Hence, the program does not contribute to gaps and overlaps which are frequently a result of categorically related programs. As a basic program providing the most expensive and intensive services, a program with categorical eligibility invariably leads to inconsistencies and inequities. This is a lesson we have learned from the Medicaid Program which is, as you know, tied to categorical eligibility.

One improvement in the method of determining eligibility for the Medically Indigent Program, however, could and should be considered. At present, eligibility is determined strictly on income and family size. This does not reflect the size of the medical expenditures. For example, particularly everyone becomes medically indigent as the size of the medical expenditures increase. No matter what the income of the individual, at some point medical expenditures do become

catastrophic. Representatives of Children's Hospital have quite effectively brought this issue to our attention. Hence, some recognition of the size of the medical expenditures in conjunction with income and family size of the consuming unit should be considered. A long stay in a high cost hospital for an individual with $12,000 of income would undoubtedly reduce that family unit to poverty levels from which escape is almost impossible.

In summary, we believe the appropriate criteria for eligibility under the Medically Indigent Program should be family size, income of family, and size of medical expenditures.

City of Colorado Springs

Target Population. Medically indigent funding has focused on the individual lacking third-party payment or their own resources. The Colorado Springs task force felt this should continue to be the emphasis, but with a health maintenance organization or state loan program, the problems of eligibility might be more effectively handled in advance of need for services, and the fluctuating status of some patients in terms of eligibility will not pose the problems it does currently from an administrative and financial perspective.

City and County of Denver

The target population for the state's Medically Indigent Program should be those individuals and families whose income and resources are committed to the essentials of life and who, therefore, do not have the flexibility to financially meet a medical care crisis, whether minor or major. Unfortunately, all too often it is impossible for individuals to determine the true severity of their medical problem.

It is self-defeating for the state to so pauperize either an individual or a family that they are in danger of losing their position in the community. A heavy and unexpected financial burden for a medical problem can set a trend for a downward spiral, in which an individual becomes progressively more dependent upon society's social institutions.

This is especially a problem for individuals not eligible for federal categorical support programs.

Catastrophic illness can affect any family at any level in society, but is especially devastating at lower income levels. We propose that the state MI Program be visualized as short-term governmental help to reduce long-term reliance.

QUESTION NO. 4: DO YOU HAVE ANY EVIDENCE THAT PEOPLE HAVE BEEN REFUSED ACCESS TO NECESSARY MEDICAL CARE BECAUSE THEY COULD NOT AFFORD TO PAY?

Colorado Hospital Association

No. If this were a problem we would have been made aware of it by the Department of Health.

Colorado Medical Society

There was no time to adequately review a grievance mechanism, but apparently it is not a big problem. We've heard of situations where patients who "physician hop" have been recognized as such and turned away.

Colorado Social Legislation Committee

Members of the Colorado Social Legislation Committee are aware of numerous examples of people who have been refused access to necessary medical care because they could not afford to pay. We shall be happy to cooperate with both this interim HEWI Committee and with the standing HEWI Committee during the next legislative session in documenting such cases.

Colorado General Hospital

a) Unmet medical needs probably exist statewide; and

b) Specific examples at Colorado General Hospital are rare.

Colorado Department of Health

While we have no specific documented evidence, we believe that there are instances where persons are refused , but refusal of care is not the only major problem. We know that many poor people seek primary care less often because of financial barriers. They usually seek care when needs become terribly acute or critical, which usually require hospital care. Such medical care needs are seldom refused because of a hospital's liability issues, Hill - Burton obligations, or for charitable reasons.

Colorado Department of Social Services

At present, we do not have any documented proof that people have been denied necessary medical care. However, we are certain that effective, efficient, and logical patterns of medical care usage have

been effected. For example, clearly the population receiving care under the Medically Indigent Program must often travel significant distances to receive such care, and frequently to higher cost hospitals. Second, we are certain that individuals who might otherwise make use of valuable preventive services might not make use of them because of the requirement to go to a hospital in order to receive benefits under the program. That is, individuals may put off consumption of services which may have the potential to lessen the incidence of more catastrophic illnesses.

City of Colorado Springs

Neither the private sector nor the public sector representatives at the meeting of the Colorado Springs task force felt that patients were turned away at the door, but it was generally conceded that persons with limited income, those known to be Medicaid, or persons whose financial resources cannot meet heavy medical expenses may indeed by shunted about within the system for more than is the maximum interest of their health or the economics of the system.

City and County of Denver

The staff of the health facilities of the Department of Health and Hospitals (Health Centers, Health Stations, Denver General Hospital) recount innumerable tales of patients unable to gain access to private care because of an absence of financial resources.

Examples of patients for whom access to private medical care has been restricted because of their inability to meet the expenses of private care:

1) An elderly man who is on Medicare had a stroke. His bill built up to $17,000 in a private hospital, at which time he transferred here. He subsequently died. He and his wife had never had any public assistance, but his catastrophic illness exhausted their savings. The wife is now being registered for care at Denver General Hospital.

2) Most of the time, Denver General Hospital has one or two young trauma patients who have been seriously injured in accidents. When it is questionable whether their recovery will be longer than one year, this agency must keep them because they cannot be certified for rehabilitation potential. In contrast, the trauma patients who clearly will be disabled for the rest of their lives can be placed on Medicaid pending and will then be accepted by an appropriate long-term health care facility.

3) A young man from a small town near Denver had been self-employed as a carpenter until recently and his wife has a shop in the town. They had no health insurance. He came

to Denver General Hospital, where he could receive care without being charged. A malignant tumor of the spine was diagnosed, with the eventual prognosis of paralysis. He will continue to use Denver General Hospital for his medical care.

4) A married couple from a community near Denver needed mental health counseling, which they could not afford in their community. They both work at relatively unskilled jobs and have no health insurance. They received mental health counseling for several months and were able to resolve their problems.

5) An eleven-year old Denver boy was critically injured in an athletic game at a recreation center. His parents own a small store and carry no health insurance. He had to remain at Denver General Hospital until he was accepted by Supplemental Security Income, at which time he was transferred to a long-term facility.

QUESTION NO. 5: FROM YOUR EXPERIENCE AND KNOWLEDGE, ARE THERE SOME PRIORITY MEDICAL SERVICES NEEDED BY THOSE PEOPLE WHO ARE GENERALLY REFERRED TO AS "MEDICALLY INDIGENT"?

Colorado Hospital Association

There is not enough data available to identify a specific pattern of need.

Colorado Medical Society

Priority Medical Services: Perinatal, Catastrophic, Emergency:

a) frequently, treatment to this group is more difficult because none are seen with proper continuing supporting or preventive care; and

b) priority should be treatment in the physicians' offices and not the emergency room, if possible.

Colorado Social Legislation Committee

a) Perinatal care for women with high risk pregnancies (see state Department of Health data).

b) Centralized outreach program to ascertain health needs of the mentally ill, the aged, working poor, etc., and dissemination of information regarding resources available to them.

c) Development of home health services for the chronically disabled.

d) Expanded dental care programs.

e) Facilitation of the ability of all residents of the state to obtain the services of competent physicians and other medical personnel.

f) Preventive health services, including education in the areas of dangers of smoking, alcohol and drug abuse, and pedestrian and driving safety.

g) Nutrition education programs.

Colorado General Hospital

a) Ob/Gyn Services.

b) Pediatric (highrisk newborn) care.

c) Acute episodes managed in rural hospitals.

Colorado Department of Health

Priority needs for the medically indigent include:

a) Improved availability -- access to services in local communities;

b) Prevention and health education services;

c) Prenatal care for pregnant women;

d) Pediatric ambulatory care;

e) Dental services; and

f) Drugs, particularly for the elderly (Medicare does not cover the cost of drugs).

Colorado Department of Social Services

We believe that hospital coverage must be the basic building block for any medically indigent program. However, once such services are provided, then expansion of the program to include additional benefits to certain target groups such as the pregnant woman would be appropriate. These individuals might thereby be encouraged to seek

medical services prior to the time for delivery where appropriate preventive care could yield significant and long lasting benefits.

City of Colorado Springs

The Colorado Springs task force felt the whole MI medical services system should be the focus of any proposed legislation and that the in-place mechanisms should be recognized and funded until viable alternatives are fully developed and operational. However, since it appears that a large portion of the services and costs of medically indigent services rendered in the municipal hospitals of Denver and Colorado Springs are related to maternity cases, and since it can be documented that a strong prenatal care program can significantly impact the health of this target population as well as significantly reduce costs, it appears feasible to give a coordination of programs and funding for these services a priority in the next legislative session's funding package. One of the ways in which this might work is to provide some local incentives to better coordinate this service. To be effective, it requires linkage with the WIC program as well as a prenatal program with lab, physician, and hospital linkage.

City and County of Denver

It seems reasonable to assume that illness and disease affect all levels of society at equal rates. However, experience has proven this assumption to be false. Communicable diseases, violence, and stress -- with their related physical disease manifestations -- are linked to social crowding and lack of resources. Similarly, emotional and psychiatric stress appears more pronounced under conditions of social limitation.

In essence, marginal social conditions and increased medical needs appear directly related, and because of the inter-relationship of social, mental, and physical illnesses, illness among the medically indigent requires an integrated multidisciplinary approach -- but again the priority of services remains as described in Answer #2.

QUESTION NO. 6: IN YOUR ESTIMATION, WHAT ARE THE POSITIVE ASPECTS AND THE SHORTCOMINGS OF THE STATE'S CURRENT MEDICALLY INDIGENT PROGRAM?

Colorado Hospital Association

The positive aspect of the program is that it is an effort to meet the needs of people, and in particular, people unable to meet their own health requirements. Adversely, the program has grown out of wedlock, so to speak, and no one "has a handle" on what is going on. Too, we have added layers of administration by having multiple programs. Should not the dollars be going to the people in need and not to administrative costs?

Colorado Medical Society

a) The current MI Program is not well distributed geographically (Denver General Hospital, Colorado Springs, Cortez, Montrose and Walsh).

b) Requirements of hospitals to provide uncompensated service of three percent discourages them to get involved.

c) The reimbursement mechanism is irrational, especially the lack of funding for physician services.

Colorado Social Legislation Committee

a) Positive Aspects:

1) Increased consciousness on the part of the General Assembly and the public of the needs of the medically indigent;

2) Money budgeted by the General Assembly for the past several years for programs for the medically indigent;

3) Addition of non-profit hospitals to those qualifying for MI funds in the 1978 Session;

4) Many deserving medically indigent persons now receiving quality care, successful inauguration of the denture program, and consideration in the 1978 Session of a perinatal program;

5) The number of physicians and dentists who do attempt to cooperate with MI programs; and

6) The existence of neighborhood health centers in Denver.

b) Shortcomings:

1) The program is not statewide in scope;

2) Comparatively few hospitals participate, therefore primary health care is not available at the local level in all instances;

3) Not all physicians in the state participate and cooperate in serving people classified as medically indigent;

4) Many of the working poor receive health care inferior to those on public assistance. Perhaps eligibility standards should be revised, e.g., consider the income of the working poor after payment of taxes. Perhaps a sliding scale comparable to day-care eligibility standards should be employed for health care; and

5) Failure to develop an adequately funded perinatal program. This year the Wyoming Legislature allocated $250,000 for a two-year program geared to the care of newborn infants meeting certain criteria of need.

Colorado General Hospital

(Answer refers to University of Colorado Medical Center)

a) Positive aspects:

1) Equal access to quality care (equipment, physician, etc.);

2) Equal access for "working poor"; and

3) Broad diagnostic and therapeutic applicability.

b) Negative aspects:

1) Omits "catastrophies" for working middle class;

2) Geographically centralized;

3) Doesn't cover full costs;

4) Doesn't cover physician fees; and

5) Doesn't cover ambulatory care (prenatal, well-child, and preventive care).

Colorado Department of Health

As we see it, the state's current Medically Indigent Program aids poor people primarily through a subsidy for certain hospitals that care for large numbers of the indigent. We believe that the state should attempt to address the broader questions of health care financial assistance for persons unable to bear the full costs of today's expensive health care system.

Colorado Department of Social Services

The principal positive aspect of the Medically Indigent Program has been the hospital services that have been made available to the indigent population of Colorado. While in the past such services may well have been ultimately provided in a particular hospital, the expanded and timely access to such services has clearly been a major program benefit. We believe this year with the expansion in participating hospitals to 13, that even greater access to needed hospital services will occur.

Other positive aspects of the current Medically Indigent Program are that the dollars provided through state appropriation are essentially all used for medical benefits rather than administrative expenditures. The state's administrative structure has placed the risk of the program upon the provider community. Under the MI Program, the incentives are for the individual provider to seek other sources of revenue before expending costs under the Medically Indigent Program.

Another positive aspect of the program is the equality under the program both in terms of the distribution of dollars among participating providers and throughout the benefit year.

In sum, the positive aspects of the program relate to the services made available, to their low administrative costs, to the incentives built into the program (not unlike incentives under the health maintenance organization concept), and to the equality in distribution of funds.

In contrast, there are still numerous shortcomings of the program. For example, the three percent free care requirement works hardships on hospitals whose medically indigent expenditures do not exceed three percent by a large amount. These hospitals, frequently rural hospitals, are not encouraged to participate in the program since they might receive a relatively small amount of reimbursement for participation in the program. As a result, fewer hospitals participate in the program, and thus those hospitals that do participate end up serving an ever increasing population.

A second shortcoming of the program is the use of the Colorado General Ability-to-Pay Scale. The Colorado General Hospital Ability-to-Pay Scale was developed for use only by Colorado General Hospital. It was not developed for use by the Medically Indigent Program. Thus, we believe that a close look at the applicability of this ability to pay scale to the needs of the Medically Indigent Program should be undertaken.

Another problem with the current Medically Indigent Program is its limited funding which does discourage participation by numerous providers. As hospitals are only reimbursed for a portion of the expenses they actually incur, they might be inclined to decline participation and thus encourage potential recipients to seek services in another hospital, thus limiting its losses under that program.

Another negative aspect of the program is lack of general knowledge on the part of the recipient community of the existence and benefit package of such program. Individuals who have never taken part in the program and who live outside of the metropolitan community may never know the existence of the program.

Wider knowledge of the program might produce a negative effect, though, as increasing numbers of recipients learn about the program, and with a stable funding level, the percentage of costs which are

covered under the Medically Indigent Program would continue to drop. This might further discourage hospitals from participating.

Finally, the current Medically Indigent Program does encourage the use of hospitals as a primary source of medical benefits. It does not encourage the use of low cost alternatives such as physician offices. Nonetheless, as expressed above, to include individual physician office visits as a benefit of the program without additional funding would further exacerbate the problems of the program. To cover physician office services for all recipients, we believe would require significant additional service benefit dollars.

City of Colorado Springs

The state is to be commended for providing state funds for a target population who clearly are "falling between the cracks" in the national health care programs. It is also clear that you as a committee are strongly motivated to examine health care for the medically indigent from a holistic approach and recognize the complexity of the system you are addressing. Your concerns for cost containment is a reality which we face together, and each segment of the service delivery system should share in that responsibility and avoid scapegoating a few who must bear the brunt of the service delivery responsibilities.

At the same time, all of us must be realistic about the taxpayers' unwillingness to underwrite any system which lacks good accountability and fails to evidence a careful stewardship of the public dollar. It is only within that context that we continue to state that under the present system, reimbursement is still woefully short of charges and the lack of coordination of the administration of the state's health care system denies a "system" and supports a costly health-wise and money-wise "non-system". A good comprehensive bill, even though it may be phased in its implementation, would be a significant step for the next session of legislature, and again, we pledge our support of your effort to achieve this goal.

City and County of Denver

The existing program has been outstanding in its recognition that health needs include all components of human illness. However, although accountability has been insured through the program's traditional fee-for-service reimbursement approach, efficient use of the health dollar has subsequently suffered. Any fee-for-service approach requires significant nonmedical expenditures in the areas of billing and payments. It would appear more cost efficient to determine "unit patient" costs and prepay annually for the total health care of a specified number of individuals. Such an approach would maximize the health benefits that could arise from a medically indigent program.

requires significant nonmedical expenditures in the areas of billing and payments. It would appear more cost-efficient to determine "unit patient" costs and prepay annually for the total health care of a specified number of individuals. Such an approach would maximize the health benefits that could arise from a medically indigent program.

Alternatives to the Current Medically Indigent Program

Medically Needy Option

One alternative to the current state-only medically indigent program might be to expand the Medicaid program to cover the "Medically Needy", thus allowing for proportional funding of the cost of the program by the federal government and the state. (The current funding ratio is 53 percent federal/47 percent state.)

The federal Medicaid program (Title XIX) authorizes the provision of medical assistance to:

(1) "Categorically needy" welfare recipients who are financially eligible to receive cash payments under the aid to families with dependent children (AFDC) program and the Supplemental Security Income (SSI) program for the aged, blind, and disabled; and

(2) "Medically needy" persons who fit the AFDC and SSI categories but are not welfare recipients because their income is higher than that of welfare recipients, although their income is insufficient to pay for their medical care.

Under the Colorado Medical Assistance Act, for the most part, only "categorically needy" welfare recipients are eligible for medical assistance under Medicaid. Some of the persons who now receive assistance under the Medically Indigent Program would qualify for Medicaid assistance if the "medically needy" option were authorized, and would therefore be supported in part by federal funding rather than totally by the state, as they are now under the Medically Indigent Program.

However, extension of the Colorado Medicaid program to the "medically needy" group would only provide a different funding source for persons who fall under the AFDC and SSI categories, i.e., who have dependent children, are aged, blind, or disabled. This type of program would not cover medically indigent persons who are single or families without children. In other words, this alternative does not duplicate the coverage of the current Medically Indigent Program. It is important to emphasize that this would not provide medical coverage for all of the "working poor", or for the "medically indigent" population in its entirety. Eligible individuals for the medically needy program would, except for excess income and resources, have to be otherwise eligible for categorical assistance as aged, blind, or dis-

abled under Title XVI of the Social Security Act or members of needy families under Title IV of the Act. This excess income and resources would have to be reduced by accrued medical expenses ("spent down") to within categorically needy assistance payment level before becoming eligible for Medicaid benefits.

It is not possible to determine how many persons who receive services under the current Medically Indigent Program would qualify under a medically needy program. However, it can be stated that single persons and couples without children in the home (unless over 65 or disabled) could, under no circumstances, qualify as medically needy, while they can currently qualify as medically indigent.

Estimated cost of medically needy option. Table III presents an estimated cost for the medically needy option in Colorado. The services which are enumerated correspond to those services which are covered under the state's Medically Indigent Program. 45 CFR 249.10 states that a Title XIX (Medicaid) State Plan may cover different services for the medically needy than for the categorically needy. Therefore, while the categorically needy are eligible for long-term nursing home care services under the Title XIX State Plan, nursing home care is not included in the cost projection because the service is not covered in the state's Medically Indigent Program, and the question of the expansion of services is not within the scope of this review of an alternative to the current medically indigent program.

Estimated number of persons eligible. The Department of Health, Education, and Welfare estimates that, among states with medically needy programs, the medically needy comprise 20 percent of the entire Title XIX eligibles. Based upon 157,000 categorically needy eligibles in Colorado the number of persons eligible for the medically needy program can be estimated at 31,400 for projection purposes, according to the national experience.

Utilization rates. The utilization rates are based on Colorado's Medicaid experience and are weighted to account for the national experience which indicates that the medically needy account for 25 to 33 percent of the total costs of medical care under the combined categorically needy and medically needy programs.

Unit cost. The unit cost for each service is based on the "Medical Budget Analysis" FY 1977"78, i.e., the unit cost for each medical service provided under Medicaid.

Total cost. The total projected cost was arrived at by multiplying the number of units of service by the unit cost, resulting in a total cost of $22,556,689, with $10,601,664 to be funded by the state.

COMPUTATION OF ESTIMATED COST OF MEDICALLY NEEDY PROGRAM

Medically Needy Services (45 CFR 249.10)	Estimated Number of Eligibles	Projected Utilization Rate 1/	Number of Units	Projected Unit Cost 1/	Projected Cost
Inpatient Hospital	31,400	3.40	106,760	$120.73	$12,889,134
Outpatient Hospital	31,400	2.22	69,708	21.52	1,500,116
Other Lab & X-Ray	31,400	3.80	119,320	6.28	749,330
Physicians Services	31,400	14.64	459,696	11.04	5,075,044
Prescribed Drugs	31,400	9.33	292,962	6.71	1,965,775
Prosthetics	31,400	1.02	32,028	11.78	377,290
				Total	$22,556,689
				(47%) State	10,601,644
				(53%) Federal	11,955,045

1/ Source: "Medical Budget Analysis - State Title XIX Payments Summary - Pay Period FY 77-78"

TABLE III

Health Maintenance Organizations (HMO's) as an Alternative Method for Providing Medically Indigent Services

In considering alternatives to the current method of providing medically indigent services solely through hospital facilities, the committee heard testimony relevant to the possibility of utilizing an HMO-type delivery system for these services. An HMO can be characterized as a direct service health plan whereby the organization assumes responsibility for comprehensive services to its member patients in a defined geographic and population area, at a fixed monthly payment.

In the course of this testimony, the committee was informed that two of the five HMO's operating in Colorado have contracts with the state to provide services to Medicaid patients in their service areas. As there has been nationwide data produced to the effect that HMO's exhibit several significant cost-containment features, the committee requested an analysis of how the state may have realized a savings by reimbursing Medicaid services through HMO's in lieu of traditional, fee-for-service providers. It was assumed that evidence of a savings in state Medicaid expenditures through HMO-delivered services would also be applicable to the provision of medically indigent services.

Ordinarily, an HMO will charge their members a "community rate" to receive services, whereby all persons, regardless of age or other factors, are charged an identical fee. In contrast, the state reimburses the HMO by determining a different capitation rate for each categorically eligible group: Old Age Pension - A, Old Age Pension - B, Aid to Dependent Children, Aid to the Needy Disabled, Aid to the Blind, and Child Welfare.

In a recent effort to analyze the results of using HMO's to provide Medicaid services, the Department of Social Services developed a comparison of the average cost for all Medicaid services statewide to the average cost for all Medicaid services in those two regions of the state that had HMO-delivered Medicaid services. These average costs were then compared to the costs for the two HMO's that provide Medicaid services. A copy of this analysis is attached as Table IV.

As the attached table indicates, the cost for HMO Medicaid services appears to exceed the average cost for both regions and for the state. The fact that these HMO capitation rates exceed regional averages is not an accurate measure of comparison, according to Dr. Buzz Sandburg, Executive Director of ChoiceCare Health Services in Ft. Collins. The factors which may render this cost comparison inaccurate include:

a) The HMO reimburses physicians at a much higher rate than the Medicaid maximum allowable payment.

b) Additional services are provided by the HMO to Medicaid recipients, in excess of what they would ordinarily receive through a non-HMO provider. The HMO provides dental ser-

vices, early and periodic screening diagnosis and treatment (EPSDT) services, routine physical examinations, and health education services that are not reimbursed under Medicaid.

c) There is no administrative cost reimbursement to the HMO for Medicaid services rendered.

d) Staff persons in the county department of social services tend to refer to the HMO those Medicaid eligibles who are in need of a high level of care.

e) The HMO provides continuing, follow-up treatment to Medicaid patients even after their eligibility ceases.

f) This cost analysis does not take into account a utilization rate, which might indicate that more health services are consumed per capita by the HMO member, whose total health needs are covered by their membership fee.

g) As a result of no data on utilization rates, this comparison does not have the potential to indicate that the cost per unit of service may be lower for HMO services than through the fee-for-service system.

Additionally, Dr. Sandburg cited the high level of satisfaction among providers because of their fiscal agent function, which makes them more accessible to local providers, and which results in payments to providers being more prompt. Also, the fact that a high percentage of local physicians participate in the HMO results in a high accessibility to services for Medicaid recipients.

TABLE IV

FY 1977 MONTHLY AVERAGE COSTS BY
CATEGORY OF CARE
REGION 2

Category	Statewide Average Rate	Region 2 Average Rate	Region 2 As Percent Of State	CCHMO Monthly Capitation	CCHMO As Percent Of State	CCHMO As Percent of Region 2
OAP-A	$ 30.73	$ 21.97	71.49%	$ 30.50	99.25%	138.83%
OAP-B	62.80	38.74	61.69	59.00	93.95	152.30
ADC	27.49	19.57	71.19	31.00	112.77	158.41
AND	83.40	54.43	65.26	76.50	91.73	140.55
AB	32.34	23.10	71.43	34.50	106.68	149.35
CW	24.08	25.12	104.32	48.10	199.75	191.48

REGION 11

Category	Statewide Average Rate	Region 11 Average Rate	Region 11 As Percent Of State	RMHMO Monthly Capitation	RMHMO As Percent Of State	RMHMO As Percent Of State
OAP-A	$ 30.73	$ 28.96	94.24%	$ 29.26	95.22%	101.04%
OAP-B	62.80	93.19	148.39	54.45	86.70	58.43
ADC	27.49	30.02	109.20	31.80	115.68	105.93
AND	83.40	60.86	72.97	83.73	110.40	137.58
AB	32.34	12.56	38.84	40.09	123.96	319.19
CW	24.08	15.67	65.07	28.18	117.03	179.83

Estimate of Those Potentially Eligible for Medically Indigent Services

Persons of poverty level income not eligible for Medicaid. It is not possible to determine how many patients have received services under the state's Medically Indigent Program since its inception in 1974, nor is it possible to arrive at a specific number of patients, by various family sizes, who would qualify as medically indigent under the ability-to-pay scale in effect for the 1978-79 fiscal year.

Since there are no figures available, an attempt to arrive at some descriptive figures resulted in using data from 1975. 1975 represents the most current time frame during which consistent data was available.

It can be stated that 73,000 people were below the Bureau of Labor Statistics' definition of poverty level ($2,717) and did not qualify for medical coverage under Medicaid. This figure was arrived at by using Colorado population figures listed in the "Spring 1976 Survey of Income and Education", published by the U.S. Bureau of the Census. 230,000 individuals were below the 1975 definition of poverty level of $2,717. By subtracting the 1975 public assistance caseload of 157,000 provided by the Department of Social Services, it was determined that the net number of individuals who did not qualify for Medicaid but who still met the Bureau of Labor Statistics' definition of "poor" would be 73,000.

A portion of the 73,000 people would be single persons and couples without children in the home (unless 65 or disabled) who, under no circumstance, would qualify for Medicaid regardless of their low standard of income. The remaining people would have income in excess of the public assistance standards but below $2,717.

Using the same methodology, it can be stated that an additional 97,000 individuals had income between $2,717 and $3,396 (125 percent of poverty level).

This latter group of 97,000, plus the 73,000 below poverty level, results in a total of 170,000 people whose income falls below $3,396 (125 percent of poverty) and who do not qualify for medical services under Medicaid. It is not possible to accurately determine the extent of third-party coverage for these individuals (see further discussion of estimates of uninsured individuals in Colorado following).

Cost for providing medical care to persons who are below poverty level but who do not qualify for Medicaid. Accurate data is not available on the medical care costs under the Medically Indigent Program. In order to project the costs involved in providing medical services similar to those provided under the current Medically Indigent Program for the 73,000 people under the poverty level, and the additional 97,000 people between the poverty level and 125 percent of poverty level, the 1978 average Medicaid inpatient hospital costs and outpatient hospital costs have been used. For FY 1977-78, the average

inpatient cost was $170.00 and the outpatient cost was $61.00. Based on these costs of care, it is estimated that the total cost for providing services to 73,000 poor persons would be $16,863,000 and for 97,000 people the program cost would be $22,407,000. The total projected cost for the target population of 170,000 would be $39,270,000 (see Table V).

TABLE V

COST PROJECTION

TARGET POPULATION 1/		X COST OF CARE	= PROJECTED PROGRAM COST 1/	
Total Persons Below Poverty Level ($2,717)	230,000			
Less -- Total Persons Eligible for Medicaid	-157,000 2/	Medicaid Inpatient 3/ $170.00 Medicaid Outpatient 3/ $ 61.00	Inpatient Cost $ 12,410,000 Outpatient Cost $ 4,453,000	TOTAL COST $16,863,000
	73,000			
Persons Between Poverty Level And 125% of Poverty Level ($3,396)	97,000	Medicaid Inpatient $170.00 Medicaid Outpatient $ 61.00	Inpatient Cost $ 16,490,000 Outpatient Cost $ 5,917,000	TOTAL COST $22,407,000
TOTAL TARGET POPULATION	170,000		TOTAL PROJECTED COST	$39,270,000

1/ Population figures are for 1975 and cost figures are for 1977-78
2/ 1975 caseload (Colorado Department of Social Services)
3/ Physician services represent 35% of cost

PREPARED BY: Legislative Council Staff, September 1978

Cost of private insurance coverage as percent of poverty level income. An individual or family whose income is within poverty levels, who is not eligible for public assistance, and who does not have access to a group policy through an employer, would have to spend a large portion of income to provide their own private insurance coverage. Using Blue Cross/Blue Shield rates for non-group rates, and comparing these to the 1978 poverty threshhold, the following table indicates the percentage of income necessary to provide minimum insurance coverage:

Size of Family Unit	Poverty Threshold	Annual Premium	Percentage of Income for Insurance Premiums
1	$3,100	$349.80	11.3%
4	$6,200	$791.40	12.8%

Estimates of persons without health insurance. A report published by the Health Insurance Institute stated that at the end of 1975, 1,921,000 Coloradoans were covered by private health insurance policies that would pay for at least some of their hospital expenses. An estimate of Colorado's total population at that time, taken from Bureau of the Census figures, was 2,537,000 persons. Therefore, about 75.7 percent of Colorado's population had at least some protection from the cost of hospital services provided to them by a policy with a private insurance company.

Health care coverage under the Medicare program was available to 8.8 percent of the state population -- 207,000 Coloradoans age 65 and over, and 16,000 persons under age 65 and disabled. The number of persons eligible for coverage under the state's Medicaid program, administered by the Department of Social Services, was approximately 156,000 persons, or 6.1 percent of the state population in 1976.

Not all of the persons eligible for Medicare or Medicaid rely exclusively upon these public programs to cover their medical expenses, as many of them also have private insurance. The total extent of this overlap is not known, except for an estimate of the number of persons age 65 and over who supplement their Medicare coverage with private insurance. The National Center for Health Statistics estimates that nationwide 55.7 percent of this group had supplementary coverage. Applying this percentage to the age 65 and over Medicare group in Colorado, 116,000 persons had duplicate coverage.

By totaling the number of persons covered by insurance from these three primary sources -- private insurance companies, Medicare, and Medicaid -- and deducting the known estimate of duplicate coverage, the number of persons estimated to have health insurance coverage is 2,184,000 as of early 1976, or 86.1 percent of the total state population, leaving 353,000, or 13.9 percent, of the state population who are assumed to be without health insurance coverage. The most often cited reason for not having health insurance coverage is its expense, especially for low-income persons.

As a means of comparing this estimate of 13.9 percent of the population without health insurance in Colorado, it was stated in the Social Security Bulletin in March, 1976, that "12 percent of the (U.S.) population has no health insurance protection under either public or private programs." (See Table VI).

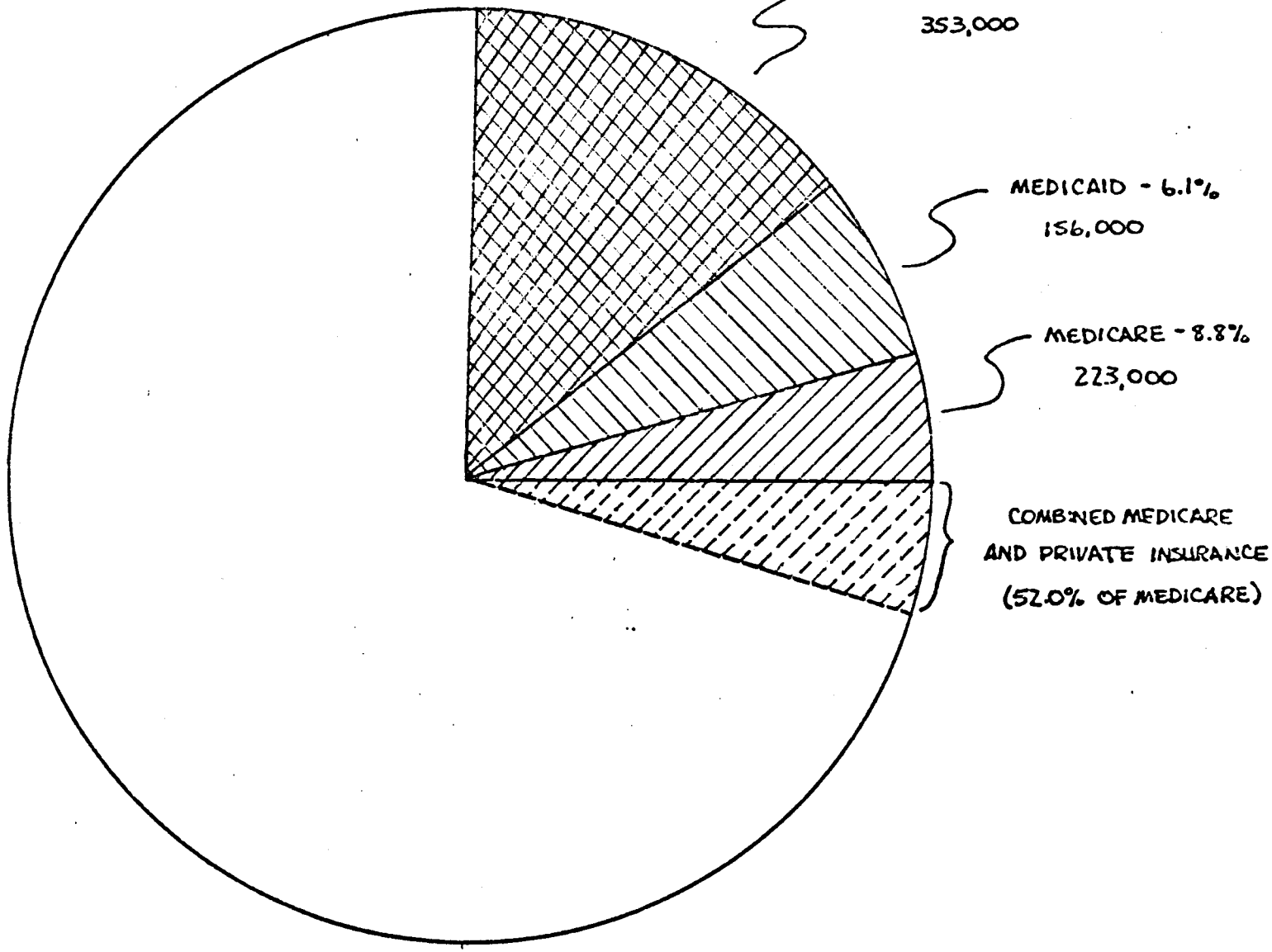
Distributions of families with annual incomes below $5,000. Table VII and corresponding Table VIII illustrate the distribution of families, by county, with annual incomes below $5,000. As an example, the first bar in Table VII indicates that 20 to 40 percent of the families in the enumerated counties have annual incomes below $5,000. In actual numbers, this represents 4100 families. (The population and income figures are for 1975 and were provided to the staff by the Colorado Department of Health.)

ESTIMATED NUMBER OF UNINSURED PERSONS

IN COLORADO - 1976

(POPULATION - 2,537,000)

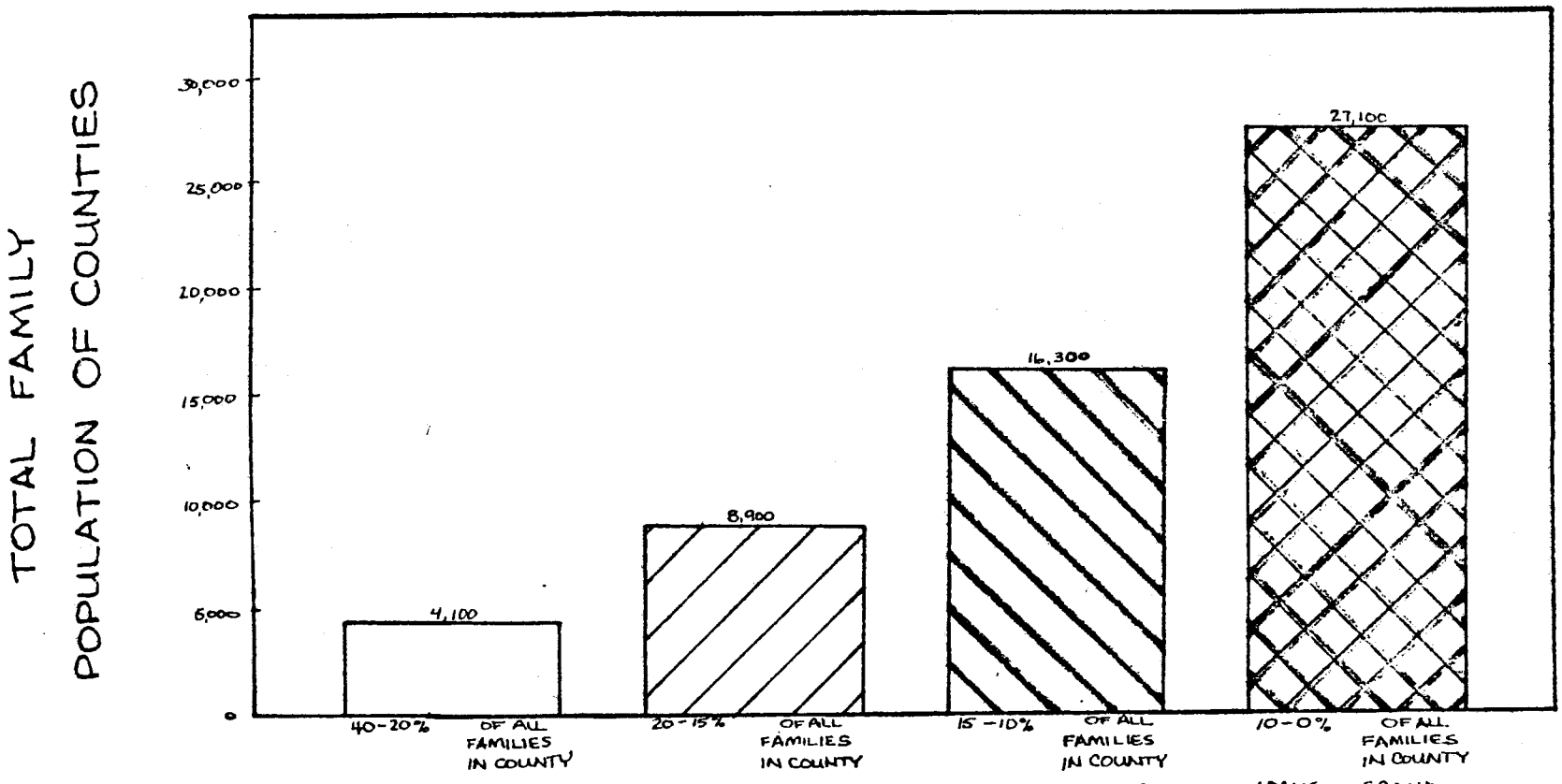
TABLE VI



PREPARED BY:
LEGISLATIVE COUNCIL STAFF
SEPTEMBER 1978

TABLE VII

PERCENTAGE OF FAMILIES OF INCOME $5,000 - OR LESS GROUPED BY COUNTY - 1975



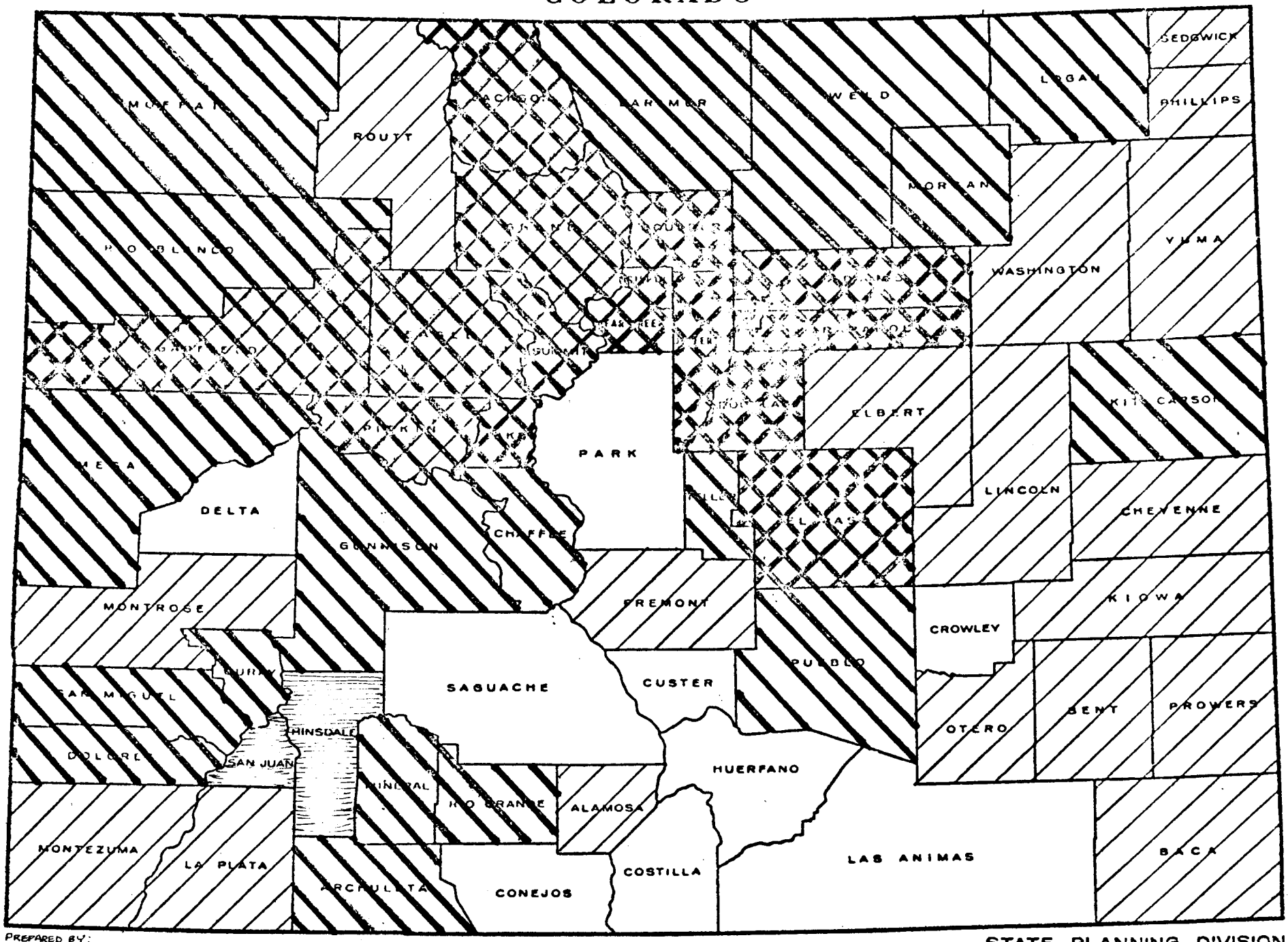
40-20% OF ALL FAMILIES IN COUNTY	20-15% OF ALL FAMILIES IN COUNTY		15-10% OF ALL FAMILIES IN COUNTY		10-0% OF ALL FAMILIES IN COUNTY	
PARK	PHILLIPS	KIOWA	LOGAN	DOLORES	ADAMS	GRAND
CROWLEY	SEDGEWICK	OTERO	MORGAN	GUNNISON	ARAPAHOE	JACKSON
HUERFANO	WASHINGTON	PROWERS	LARIMER	OURAY	BOULDER	PITKIN
LAS ANIMAS	YUMA	ALAMOSA	WELD	SAN MIGUEL	CLEAR CREEK	SUMMIT
CONEJOS	GILPIN	LA PLATA	TELLER	MESA	DENVER	LAKE
COSTILLA	CHEYENNE	MONTEZUMA	KIT CARSON	MOFFAT	DOUGLAS	
SAGUACHE	ELBERT	MONTROSE	PUEBLO	CHAFFEE	JEFFERSON	
DELTA	LINCOLN	ROUTT	MINERAL		EL PASO	
CUSTER	BACA	FREMONT	RIO GRANDE		GARFIELD	
	BENT		ARCHULETTA		EAGLE	

NO DATA AVAILABLE FOR SAN JUAN HINSDALE

PREPARED BY:
LEGISLATIVE COUNCIL STAFF
SEPTEMBER 1978

TABLE VIII

COLORADO



PREPARED BY:
LEGISLATIVE COUNCIL STAFF - SEPTEMBER 1978

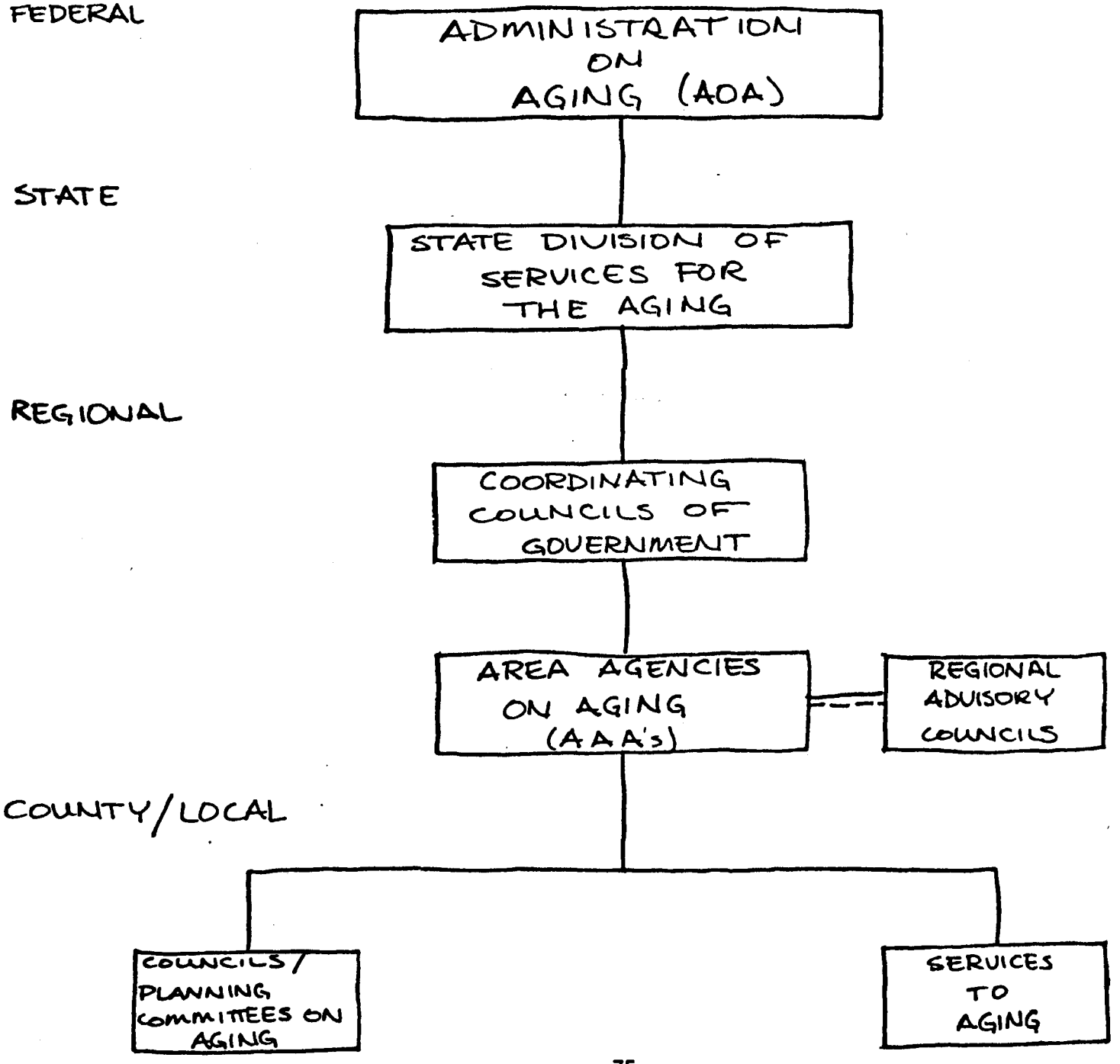
STATE PLANNING DIVISION

Senior Citizens

Aging Administration in Colorado

In response to the federal Older American's Act of 1965 (Public Law 89-73) and subsequent amendments, a multitiered aging administration has evolved in Colorado at the state, regional, and local levels. (See Exhibit 1)

EXHIBIT 1 /



State Level

The Division of Services for the Aging was established by administrative action of the Executive Director of the Department of Social Services. It has no state statutory duties or functions but serves as the designated organizational unit within the Department of Social Services to administer programs set forth in the Older Americans Act and the State Center Grants program (established by the General Assembly in the long appropriations bill). Responsibilities of the division which are determined by federal law, rather than state law, include: statewide planning, coordination, and evaluation of the programs and activities of thirteen Area Agencies on Aging and fifteen Nutrition Projects.

The division is staffed with ten FTE's for FY 1978-79 and organized into three major units: (1) the Director's Office; (2) the Grants Management and Fiscal Control Unit; and (3) the Program Operations and Evaluation Unit.

(1) The Director's Office. This unit includes two FTE's - the director and a secretary. In addition to the overall administrative responsibilities of staff supervision, fiscal planning and accountability, the director develops policy, provides leadership and direction in program development, implementation, and coordination of statewide programs serving older persons. The director is responsible for the preparation of the annual State Plan on Aging (required by the Older Americans Act), and has the assistance, on a part-time basis, of the planner on the staff of the Title XX Division of the Department of Social Services. The director is also responsible for leadership and direction for the Colorado Commission on Aging.

(2) The Grants Management and Fiscal Control Unit. This unit is staffed with three FTE's - two administrative officers III's and a secretary. The unit is responsible for the receipt, review, and processing of grants to all Area Agencies on Aging, Nutrition Projects, and recipients of State Grant Funds. The unit monitors, assesses, and evaluates the fiscal management of funds allocated to the network agencies and works to improve statewide fiscal accountability through provision of technical assistance training. The grants Management and Fiscal Control Unit works closely with the department's Office of Accounting and Office of Field Audits.

(3) The Program Operations and Evaluation Unit is staffed with five FTE's and one contract person - a program administrator heads the unit and supervises two aging services supervisors, one Title VII nutrition specialist, a legal services developer (contract) and a secretary. The unit is responsible for the planning, implementation, monitoring, assessing, and evaluating of programs and activities of the Area Agencies on Aging and Nutrition Programs in accordance with federal and state regulations.

The Title VII nutrition specialist serves as a consultant in nutrition and food management to the supervisors of the nutrition

projects. The nutrition specialist participates in the monitoring, assessing, evaluating, and training activities related to the Nutrition Program. The legal services developer, a contract position funded by an Administration on Aging grant, develops needed legal services for older persons through governmental agencies and private agencies and organizations, including bar associations.

There is currently no staff responsible to coordinate, at the state level, all programs serving older persons, to serve as a clearinghouse for all federal funds for aging programs, or to develop additional resources for initiating or expanding services for older citizens.

Colorado Commission on the Aging. The Commission, created by Article 11 of Title 26, consists of thirteen members appointed by the Governor. Two members represent each congressional district, with one member appointed from the state at-large. Amendments adopted in 1977 added one member from the Senate and one member from the House of Representatives to the membership of the commission. The commission is the only statutory unit of state government established solely for the purpose of providing services to older persons in Colorado and acts in an advisory capacity to the Division of Services for the Aging. The Director of the Division of Services for the Aging, who is appointed by the Executive Director of the Department of Social Services, serves in a dual capacity as both the director of the commission and the division.

The duties of the commission, as prescribed by statute, are to:

- conduct studies on the problems of the state's older citizens;
- assist governmental and private agencies to coordinate their activities;
- aid in the establishment of local programs for the aged;
- design surveys to determine the needs of the elderly in the state;
- collect and distribute information on programs and services for the elderly;
- recommend creation of services for the elderly;
- conduct educational programs;
- review existing programs and make recommendations to the Governor and the General Assembly for improvements in the programs; and
- review and approve applications for $110,000 in state center grants (per footnote to H.B. 1252, 1978 long bill).

In addition to the duties prescribed by state law, the commission performs other functions which are required in order for the state to receive federal funds under the Older Americans Act. In practice, the following activities required by federal law and regulation constitute the majority of the activities of the commission:

- conduct hearings on the annual State Plan on Aging; and

- advise the Division of Services for the Aging and the Governor on the implementation of the State Plan on Aging. (The plan is written exclusively for Titles III and VII of the Older Americans Act and does not include other related activities or services for senior citizens funded by the state or local units of government or other federal agencies).

Regional Level

In order to comply with the Older Americans Act, Colorado established the Area Agencies on Aging and the Regional Advisory Councils.

Area Agencies on Aging. The Older Americans Act provides for the designation of Area Agencies on Aging (AAA's). As of January 1, 1979, there will be thirteen AAA's in Colorado corresponding with the thirteen Planning and Management Districts in the state. Previously, the state had only 11 designated AAA's.

A full-time director is required for each AAA. This person is employed by and responsible to the respective regional governing body. The AAA is a separate agency under the regional government with administrative support provided by the respective council of governments. The only direct personnel relationship which the division has to the AAA directors is through the evaluation of program performance.

From testimony received by the committee the functions of the AAA's are identified as the following:

1) Provision of leadership and advocacy on behalf of all older persons within the planning and service area for which the Area Agency is responsible;

2) Determination of the need for social services in the planning and service area with special attention being given to the needs of low-income and minority elderly, and to the extent feasible, with respect to resources made available under the plan that low-income and minority individuals will be served at least in proportion to their relative numbers in the planning and service area;

3) Inventory of the resources within the planning and service area to meet the needs of the elderly, and an evaluation of

the effectiveness of the services provided by the public and private agencies within such areas in meeting such needs;

4) Establishment of measurable program objectives and priorities for implementation of the area plan through the development of specific action steps in keeping with the objectives established by the state agency;

5) Planning with existing planning agencies and the providers of service in the area concerning the needs of the elderly;

6) Either directly, or through contract or grant, provide for an action program designed to coordinate the delivery of existing services for the elderly and pool available but untapped resources of public and private agencies in order to strengthen or inaugurate new services for older persons;

7) Periodic evaluation of activities carried out under the area plan, including the views of older persons participating in such activities, and monitoring on an ongoing basis the performance of contracting agencies and grantees under the area plan;

8) Conduct of periodic public hearings concerning the needs of the elderly in addition to the conduct of a public hearing(s) on the area plan;

9) Collection and dissemination of information concerning the needs of the elderly;

10) Provision of technical assistance to providers of social services in the planning and service area; and

11) Where necessary and feasible, enter into agreements with local human service agencies' services to older persons in the planning and service area to be carried out through federally assisted programs or other public or non-profit agencies.

The Area Agencies on Aging are responsible for: program planning; coordination of existing services; and pooling of existing, but untapped resources. Based on the regional plans that are developed, the Area of Agencies on Aging are responsible for contracting (with Older Americans Act funds) for services conforming to the Act and to the priorities for their region which appear in their plan.

The Area Agencies on Aging must bring together, at the service provision level, public resources from various levels of government into a service system based on the priorities in their plan. Many of these resources reach the service provision level without flowing through any state agency or being subjected to the appropriation process.

Regional Advisory Councils. The Regional Councils Act as the advisory councils outlined in the Older Americans Act. They advise the AAA's on matters relating to the administration and operation of the area plan. Regional advisory councils hold meetings in different locations each month to allow all persons to voice their concerns directly to the council. A regional council is required by the Older Americans Act to have at least 50 percent membership from the consumers of services provided.

Local Level

The majority of service providers are operative at the local level. Not all services provided are part of the aging administration in Colorado. In addition to the programs under the auspices of the Older Americans Act, there are numerous programs offered by public, private, and private non-profit agencies.

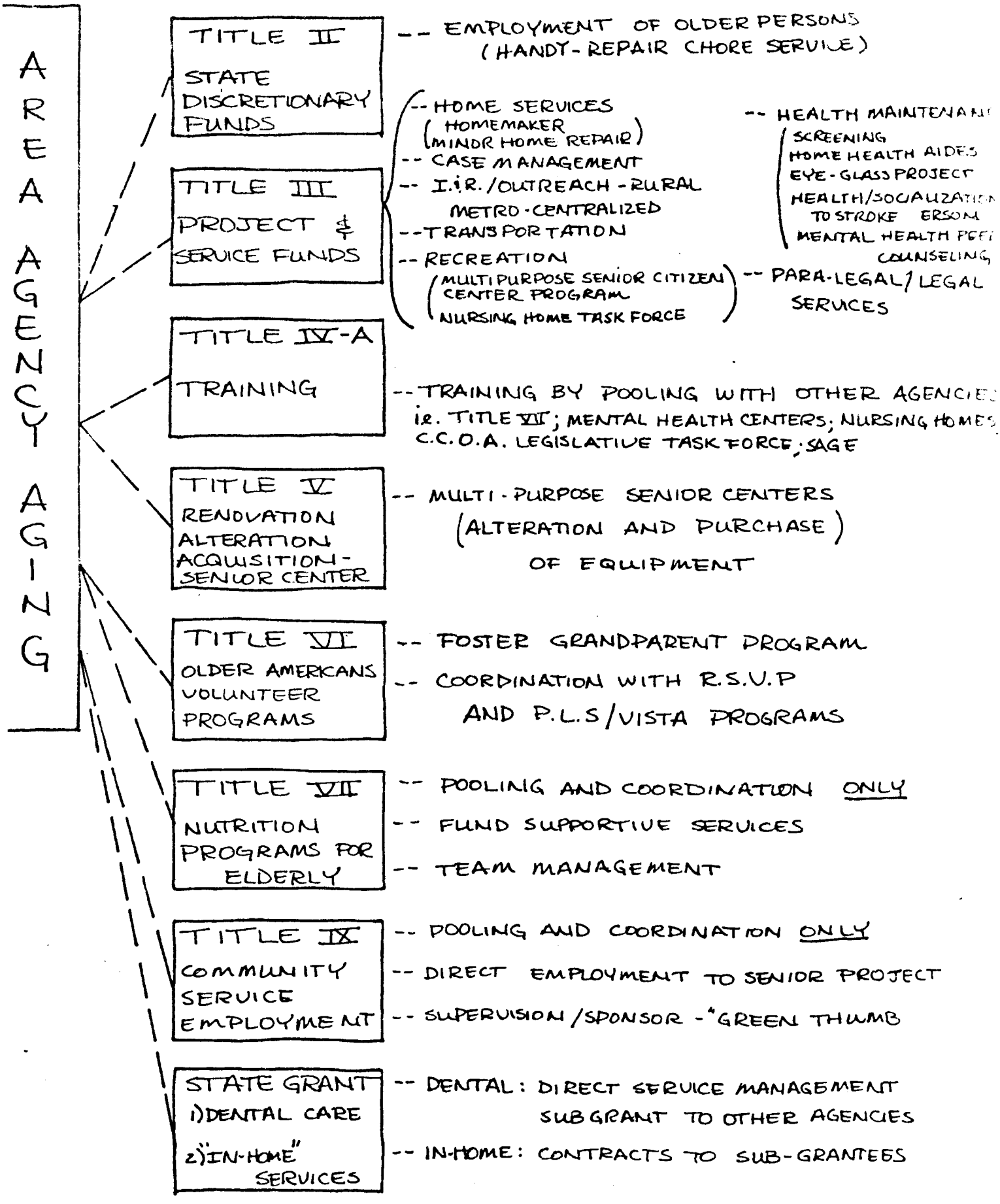
Multiple programs funded through Titles II, III, IV - A, V, VI, VII, and IX of the Older Americans Act and the State Center Grants Program are administered by the AAA's to local service providers (See Exhibit 2). The Title VII Nutrition Projects operate independently of the AAA at the local level 1/

Title VII Nutrition Projects. The Title VII Program is designed to serve nutritionally sound meals, at a low cost, and provide supportive social services to persons through improved nutrition. The program also helps reduce isolation of older persons by offering them an opportunity to participate in community activities plus transportation to the meal site. All elderly persons 60 years of age and older can receive one hot meal a day, five days a week under this program.

Nutrition program agencies provide many services not directly supported by Title VII funds but which are required as a condition for funding. These services include: nutritional education, health and welfare counseling outreach, information and referral, recreation, shopping assistance and escort (as funds and personnel permit). The match formula for the Nutrition Program is 90 percent federal funds and 10 percent local funds.

1/ In 1978 the Older Americans Act was amended to consolidate Titles III, V, and VII. Whereas the Nutrition Projects had operated independently of the Area Agencies, now they will be combined with the other programs under control of the AAA's to coordinate the support services previously provided under all three title programs.

EXHIBIT 2


AREA AGENCY AGING
TITLE II
STATE DISCRETIONARY FUNDS
-- EMPLOYMENT OF OLDER PERSONS (HANDY-REPAIR CHORE SERVICE)
TITLE III
PROJECT & SERVICE FUNDS
-- HOME SERVICES (HOMEMAKER MINOR HOME REPAIR)
-- CASE MANAGEMENT
-- I.I.R./OUTREACH - RURAL METRO - CENTRALIZED
--TRANSPORTATION
-- RECREATION (MULTIPURPOSE SENIOR CITIZEN CENTER PROGRAM NURSING HOME TASK FORCE)
-- HEALTH MAINTENANCE SCREENING HOME HEALTH AIDES EYE-GLASS PROJECT HEALTH/SOCIALIZATION TO STROKE ERSON MENTAL HEALTH COUNSELING
-- PARA-LEGAL/LEGAL SERVICES
TITLE IV-A
TRAINING
--TRAINING BY POOLING WITH OTHER AGENCIES ie. TITLE VII; MENTAL HEALTH CENTERS; NURSING HOMES C.C.O.A. LEGISLATIVE TASK FORCE; SAGE
TITLE V
RENOVATION ALTERATION ACQUISITION - SENIOR CENTER
-- MULTI-PURPOSE SENIOR CENTERS (ALTERATION AND PURCHASE) OF EQUIPMENT
TITLE VI
OLDER AMERICANS VOLUNTEER PROGRAMS
-- FOSTER GRANDPARENT PROGRAM
-- COORDINATION WITH R.S.V.P AND P.L.S/VISTA PROGRAMS
TITLE VII
NUTRITION PROGRAMS FOR ELDERLY
-- POOLING AND COORDINATION ONLY
-- FUND SUPPORTIVE SERVICES
-- TEAM MANAGEMENT
TITLE IX
COMMUNITY SERVICE EMPLOYMENT
-- POOLING AND COORDINATION ONLY
-- DIRECT EMPLOYMENT TO SENIOR PROJECT
-- SUPERVISION/SPONSOR - "GREEN THUMB
STATE GRANT
1) DENTAL CARE
2) "IN-HOME" SERVICES
-- DENTAL: DIRECT SERVICE MANAGEMENT SUBGRANT TO OTHER AGENCIES
-- IN-HOME: CONTRACTS TO SUB-GRANTEES

County Advisory Councils. County councils act as advisory groups to the Regional Advisory Councils and the AAA's as well.

A council generally has representation from all the organized senior groups in the area, but any interested senior citizen may be a council member. There is an executive board of seven to eleven members. Like the Regional Advisory Councils, these councils provide a forum for input from seniors at the local level.

Administrative and Programmatic Deficiencies of Division of Services for the Aging

Deficiencies in FY 1979 State Plan on Aging. The committee heard testimony throughout the interim concerning deficiencies in the administration of aging programs by the Division of Services for the Aging in the Department of Social Services. Due to fiscal and programmatic shortcomings cited in federal audit reports, and to the inability of the division to properly address these shortcomings in its FY 1979 State Plan on Aging, the Administration on Aging in Washington placed a number of restrictions on the division for the continued receipt of federal aging funds.

After submitting a draft copy of the FY 1979 plan to the Regional Office on Aging in Denver, the Director of the Department of Social Services was notified by the Regional Office that their review indicated that "the Division is not meeting some of the basic functions and responsibilities as stipulated by the law and regulations." This statement was based on the findings of two audit reports, one prepared by the Office of the Inspector General in the Department of Health, Education, and Welfare, and also from a program assessment completed by the Regional Office.

Relevant to these findings, the Regional Office directed the division to incorporate in the final draft of the plan specific actions they would undertake to address the deficiencies. As cited, the deficiencies were:

1) The need to immediately implement an improved fiscal management system of the state division and aging network;

2) The need to ensure an adequate system for the receipt of financial and performance reports about the division's activities;

3) The failure of the division to conduct quarterly assessments of the field programs it supervises;

4) The failure of the division to develop and implement a policies and procedures manual;

5) The need to ensure that adequate information and referral services are available to older citizens throughout the state; and

6) The lack of adequate numbers of qualified, full-time staff in the division.

In response to these mandates, the Director of the Department of Social Services advised the Regional Office on Aging that every effort would be made to address these deficiencies, and he outlined remedial actions that were being taken immediately, and which would be incorporated in the final draft of the FY 1979 State Plan on Aging.

Difficulties in the relationship of the Division of Services for the Aging and community-based programs. The Division of Services for the Aging supervises a number of direct service programs that are authorized and funded by the Older Americans Act. Testimony from representatives of these direct service programs was heard by the committee, and several issues relating to difficulties in the relationship of the division to the direct service programs were noted:

- the limited resources available to the division with which to provide support to direct service programs;

- the lack of sufficient and qualified division staff specialists to provide necessary technical assistance at the direct service level;

- the multitude of required forms, the lateness in receiving the forms, and the unrealistic deadlines for their completion;

- the numerous mandates and regulations from the division that affect the provision of direct services;

- the need for the division to define its role as one of providing advocacy, support, and technical assistance to the agencies delivering services to the elderly; and

- for the division to recognize the unique relationships between service delivery agencies and their local governmental units. (See Exhibit 3).

EXHIBIT 3

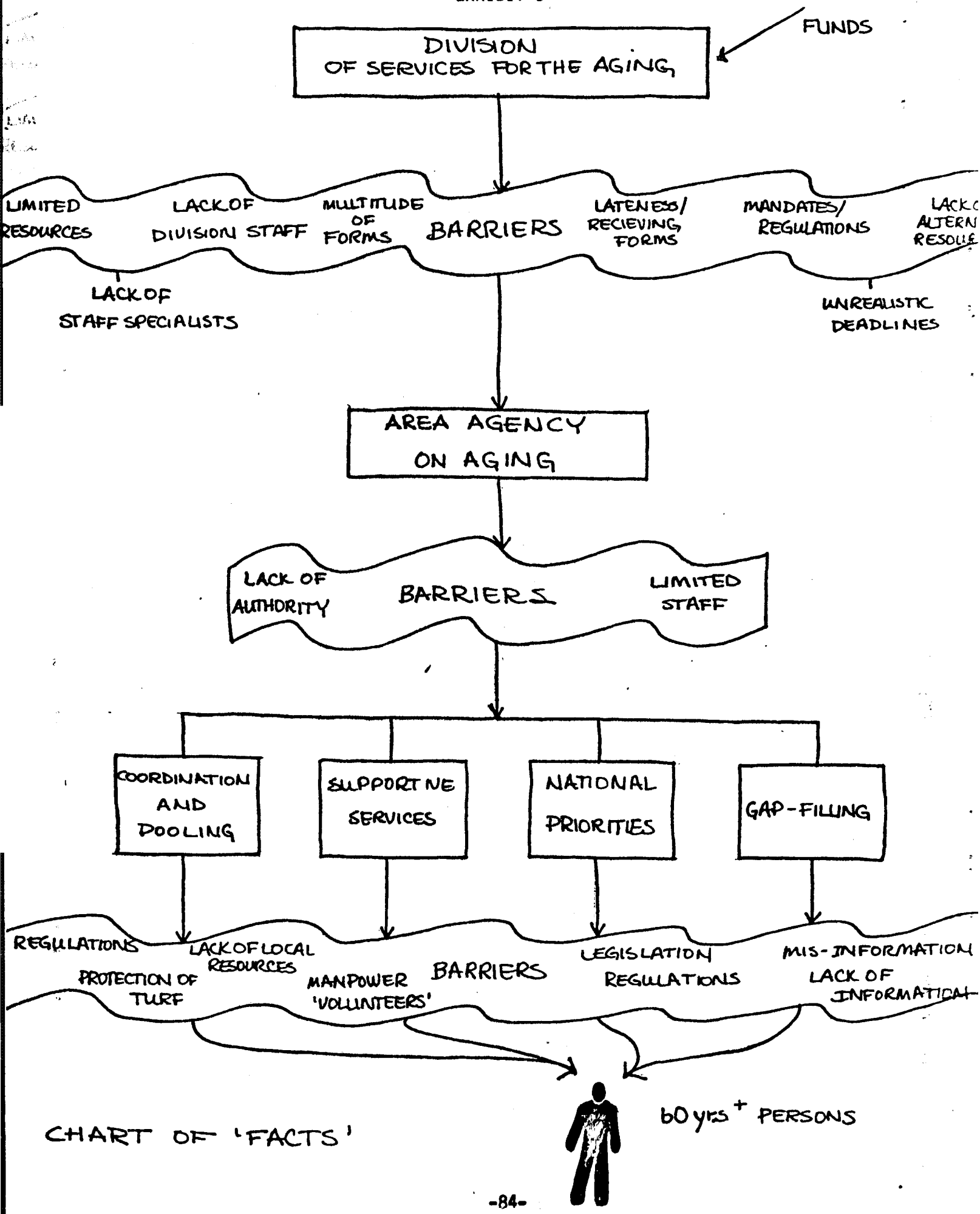


CHART OF 'FACTS'

Conditional approval of Colorado's State Plan on Aging. In conditionally approving Colorado's 1979 State Plan on Aging, the U.S. Commissioner of Aging cited the recent audit of the division conducted by the Office of the Inspector General in the U.S. Department of Health, Education, and Welfare. A summary of deficiencies based on audit findings was contained in the Commissioner's letter to the Governor, dated September 30, 1978, similar to those communicated to the Department of Social Services in an earlier letter from the Regional Office on Aging:

1) Financial management deficiencies prevented auditors from expressing an opinion on the allowability of costs claimed for services under Titles III and VII.

2) The information reported on Titles III and VII Financial Status Reports did not represent the actual results of the aging program.

3) The State Agency's financial management system did not provide for effective control over the accountability of subgrant funds.

4) The State agency did not evaluate Title III and VII programs in accordance with Federal program requirements.

   Since the State agency did not have adequate financial information the auditors could not determine if:

   (1) Federal funds were properly expended and matched.

   (2) The State agency met the required maintenance of effort.

   (3) Costs of the development and administration of area plans were limited to 15 percent.

   (4) The non-federal share of total expenditures under the Title III program was provided from State or local public sources.

   (5) Federal funds used for Title VII supporting social services were limited to 20 percent of the State's allotment for each fiscal year.

Based on the findings of this audit, the commissioner instructed the Administration on Aging Regional Office in Denver to conduct an assessment report of community-based programs supervised by the division. He noted that this report also indicated that "basic administrative and program requirements are not being fulfilled." Additionally, the U.S. Commissioner on Aging was critical of the division, citing its ineffectiveness in developing services and in serving as an advocate for the elderly in Colorado.

Report of Office of the State Auditor. In consideration of these findings, the committee expressed its desire to obtain a written response from the Office of the State Auditor as to any audit findings it may have compiled addressing these deficiencies, what previous recommendations it may have made in response to these finding of deficiencies, and in what form the findings and recommendations were transmitted to the General Assembly. Specifically, the Office of State Auditor is to address the question of "staff capabilities" and the lack of fiscal accountability on the part of the division. The committee requested that this response be submitted to the General Assembly by January 1, 1979.

By way of a preliminary response, the Office of the State Auditor informed the Legislative Council staff that a detailed audit of the Department of Social Services, as well as of the Division of Services for the Aging, was completed in 1976 for fiscal years 1973-74 and 1974-75. At that time, several fiscal and programmatic deficiencies were cited in the auditor's report to the Legislative Audit Committee, and were reported as having been acted upon by the division. This information, as well as further documentation of any fiscal management deficiencies will be included in the January 1, 1979, report to the General Assembly from the Office of State Auditor.

Demographic Characteristics of Older Coloradoans

This section was prepared to provide some basic data on Colorado's older citizens. For reasons of consistency, and because it seems to be the most often used definition, the group age 65 and over was defined as "older".

Population

According to estimates of population recently provided by the Colorado Division of Planning, the following table shows the relationship between the aged population and the estimated total population in 1976:

	1976 Population Estimates
Colorado Population	2,575,404
Aged 65 and over	216,051
Percent age 65 and over	8.4%

Although estimates of population at given points in time vary between the sources, all sources gave a similar estimate of the percentage of aged Coloradoans to the state's total. A recent publication by the National Clearinghouse on Aging (provided by the Department of Local Affairs, Division of Planning) reported that the percentage of the over-65 age group to the state's total population

decreased from 8.5 percent in 1970 to 8.3 percent in 1975. According to the Clearinghouse, Colorado was the only state to experience this percentage decrease in older citizens. The 1975 figure of 8.3 percent ranks Colorado 44th among the states, in their report, with Florida's 16.1 percent ranking first, and Alaska's 2.4 percent ranking last.

County distribution. According to the Division of Planning figures, approximately 77 percent of the state's 65 and over population reside in ten of the state's 63 counties in 1976:

County	1976 Population Age 65 and Over	Percent of Total County Population	Percent of Total State Aged Population
Denver	60,971	13.0%	28.2%
El Paso	16,964	5.7	7.9
Jefferson	16,766	5.4	7.8
Pueblo	12,560	10.3	5.8
Boulder	11,082	7.2	5.1
Arapahoe	10,722	4.8	5.0
Larimer	10,608	8.9	4.9
Adams	9,920	4.2	4.6
Weld	9,188	7.9	4.3
Mesa	7,556	11.0	3.5
	166,387	78.4%	77.1%

The distribution of the state's elderly between urban, rural nonfarm, and rural farm areas, as reported in the 1970 census, is as follows:

	Age 65 and Over	Percent of Age 65 and Over	State Total Population
Urban	146,614	77.9%	78.7%
Rural Nonfarm	34,723	18.5	16.6
Rural Farm	6,754	3.6	4.7

The distribution of aged people in these three categories is not significantly different than the distribution for the state's

population. The Bureau of the Census defines "urban" as either an "urbanized area" consisting of at least one city of 50,000 or more in 1970 and the surrounding closely settled areas, or places of 2,500 or more outside of an "urbanized area".

Mean incomes. The following table shows the relationship between the mean (average) income of the state's age 65 and over population to the state's total population mean income as reported in the 1970 census:

	Mean Incomes		
	Age 65 and Over	Total Population	Percentage Difference
Urban Male	$4,892	$7,828	-37.5%
Urban Female	2,423	3,253	-16.3
Rural Nonfarm Male	3,607	7,129	-49.4
Rural Nonfarm Female	2,044	2,718	-24.8
Rural Farm Male	4,214	6,346	-33.6
Rural Farm Female	2,010	2,648	-24.1

This table shows that the mean income for aged people in the state ranged from 16.3 percent to 49.4 percent lower than the mean income for the general population situated in similarly-sized areas.

Mean family incomes by household from the 1970 census are as follows (either male or female head of household):

Mean Income by Family	All Heads of Household	Age 65 and Over Heads of Household	Percentage Difference
State Total	$10,838	$7,344	-32.2%
Urban	11,227	7,836	-30.2
Rural Nonfarm	9,667	5,820	-39.8
Rural Farm	8,632	6,538	-24.3

The table indicates that the mean income for families with an aged head of household ranges from 30.2 percent to 39.8 percent lower than the mean income for all families in similarly sized areas.

Poverty levels. The following table shows the number of persons in the age 65 and over population and the total state population whose income was below established poverty levels at two points in time -- from 1970 census data, and the 1976 Survey of Income and Education by the Bureau of the Census:

1970

	Percentage of Total Age 65 and Over	Percentage of Total Population
Income below poverty level	25.1%	12.3%
Income below 125% of poverty level	32.9	17.1

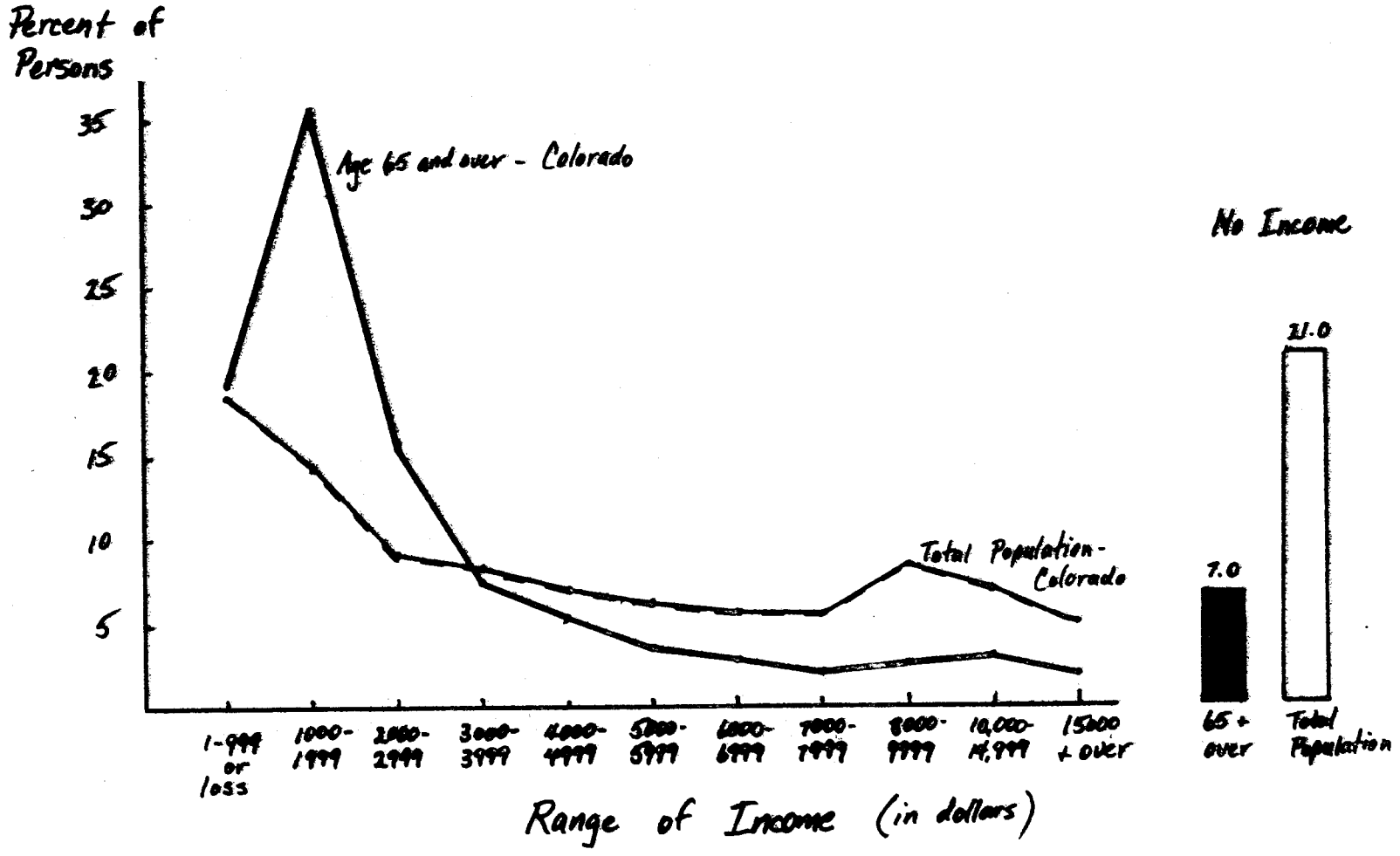
1976

	Percentage of Total Age 65 and Over	Percentage of Total Population
Income below poverty level	14.1%	9.1%
Income below 125% of poverty level	22.0	12.9

These figures demonstrate the larger incidence of poverty level incomes among the aged in Colorado as compared to the total state population. As the 1976 figures indicate, the percentage of persons with poverty level incomes decreased for both this group and in the population at large, according to the Bureau of Census computations.

Distribution of incomes. Exhibit 4 depicts the distribution of income levels over the range of incomes for the elderly group and the state's total population. As indicated in the chart, a much smaller percentage of the age 65 and over group had no income, but 35.4 percent of the elderly that did have an income were in the $1,000-$1,999 range (as compared to 14.7 percent for the state's population at large).

Percentage Distribution by Income



Source: 1990 Census

EXHIBIT 4

The following table summarizes the data on Exhibit 4:

Distribution of Income (1970)

	Age 65 and Over %	Total State Population %
$ 1 to $999 or less	19.3	18.5
$ 1,000 to $ 1,999	35.4	14.7
$ 2,000 to $ 2,999	15.4	9.5
$ 3,000 to $ 3,999	7.7	8.2
$ 4,000 to $ 4,999	5.6	7.1
$ 5,000 to $ 5,999	3.8	6.6
$ 6,000 to $ 6,999	2.9	6.3
$ 7,000 to $ 7,999	2.1	5.7
$ 8,000 to $ 9,999	2.6	8.6
$10,000 to $15,000	2.9	9.7
$15,000 or more	2.3	5.1
Persons without income	7.0	21.0

Employment

The following table summarizes 1970 census data regarding the employment status of the age 65 and over population as compared to the state's total population:

	State Total		Age 65 and Over	
	Male	Female	Male	Female
Total	737,161	778,621	79,672	108,419
Labor Force*	578,719	331,934	19,645	10,092
% of Total	78.5%	42.6%	24.7%	9.3%
Employed**	557,775	316,521	18,954	9,738
% of Total	75.7%	40.7%	23.8%	8.9%
Unemployed	20,944	15,413	691	354
% of Total	2.8%	2.0%	0.9%	0.3%
Not in Labor Force	158,442	446,687	60,027	98,327
% of Total	21.5%	57.4%	75.3%	90.7%

*Includes Military.

**Includes full-time or part-time, with a job but not at work, and military.

Housing

The following data on housing and occupancy characteristics in Colorado were obtained from the 1970 census, and from a special report by the Bureau of the Census in 1970 entitled Housing of Senior Citizens. Though many housing factors have changed since 1970, especially the value of homes, this information may serve as a general comparison between the housing characteristics of the age 65 and over population to Colorado's total population.

Owner-occupied and renter-occupied units. The following table shows a comparison between home owners and renters in both the age 65 and over group and the state total population. Also shown are the characteristics of occupancy:

	Owner and Renter-Occupied Units			
	Age 65 and Over		Total State Population	
	Number	Percent	Number	Percent
Owner-occupied units	80,403	68.3	438,148	63.4
1 person	27,158	(33.8)	49,771	(11.4)
2 or more persons	53,245	(66.2)	388,377	(88.6)
Renter-occupied units	37,240	31.7	252,780	36.6
1 person	24,162	(64.9)	74,810	(29.6)
2 or more persons	13,078	(35.1)	177,970	(70.4)
Total Units	117,643	100.0	690,928	100.0

The percentage of the number of persons who own their homes to the number of persons who rent is approximately the same in both the age 65 and over group and in the total population. A significant difference, though, is seen in the occupancy of rental units -- about 65 percent of the persons in the age 65 and over rental group live alone, whereas about 30 percent of the renters of all ages in the state are living alone.

Year moved into home. The following table shows the year in which either the owned home or the rental unit was first occupied by persons aged 65 and over as compared to state totals:

Year Owned or Rented Home First Occupied

Owner-occupied Units	Age 65 and Over Percent of Owners	Total State Population Percent of Owners
1965 to 1970	19.1	44.5
1960 to 1964	14.5	20.6
1950 to 1959	25.8	21.1
1949 or earlier	40.6	13.8
	100.0	100.0

Renter-occupied Units	Percent of Renters	Percent of Renters
1965 to 1970	58.1	85.2
1960 to 1964	18.7	7.7
1950 to 1959	13.5	4.6
1949 or earlier	9.7	2.5
	100.0	100.0

Renter occupancy shows a similar trend in both the age 65 and over group and in the state as a whole -- a majority of rental units have been occupied for five years or less. Owner-occupancy, however, shows a near opposite trend between homeowners age 65 and over and those in the total state population -- the largest percentage of those age 65 and over have lived in that home in excess of 20 years, in contrast, the largest percentage of the homeowners in the total state population have lived in that home for five years or less.

Financial characteristics of housing. Shown below is a comparison of the values of owned homes in the age 65 and over group and in the total state population. Also shown is a comparison of gross rent characteristics (actual rent plus estimated average monthly cost of utilities) for age 65 and over renters and for the state total population. This information, though outdated, is the most current that was avilable for the purposes of this comparison.

Financial Characteristics of Owned and Rented Homes

Value of Owner-occupied Homes	Age 65 and Over Percent	Total State Population Percent
less than $ 5,000	8.2	3.3
$ 5,000 to $ 9,999	25.8	11.9
$10,000 to $14,999	30.0	22.1
$15,000 to $19,999	18.4	26.1
$20,000 to $24,999	8.1	16.3
$25,000 or more	9.5	20.3
	100.0	100.0
Median value of homes (1970)	$13,300	$17,400
Gross Rent for Renter-Occupied Units		
less than $60	24.8	10.7
$ 60 to $ 79	20.7	13.6
$ 80 to $ 99	15.6	15.1
$100 to $149	21.7	33.9
$150 to $199	6.1	14.7
$200 or more	3.1	6.2
No cash rent	8.0	5.8
	100.0	100.0
Median gross rent (1970)	$ 83	$ 110

Compilation of State-Funded Programs for the Elderly

In order to obtain information on the various programs available to senior citizens in Colorado, a questionnaire was submitted to each of the principal executive departments asking for a brief program description, funding sources, and numbers of elderly clients served by the departments' programs for the elderly. The assembled data, derived from the responses to the questionnaires and testimony received by the committee, represents a compilation of state-funded senior citizen programs as outlined by the committee's study directive.

APPENDIX A

~~Colorado Hospital Association~~

County Hospitals

MEDICALLY INDIGENT SURVEY

2A. Meeting free care obligation by:

a. open door policy
b. 3% of oper. expense
c. 10% of orig. amount of loan

Hospital & Bed	2. Hill-Burton Hospital?	a.	b.	c.	2B. Do you interview for ability-to-pay?	2C. Ability-to-pay scale enclosed?
1-56	Yes		x		Yes	No
2-20	Yes	x			No	No
3-98	Yes	x			No	No
4-334	Yes			x	Yes	Yes
5-19	Yes	x			Yes	No
6-75	Yes			x	Yes	Yes

Hospital	2D. Eligibility for M. I.	2E. Do you have definition for medically indigent?	3. Previous or present participation in M.I. Program?	3A. If so, what years & how much
1	Anyone expressing a need.	No	No	
2	Patient Request	No	No	
3	Patient Interview	No	No	
4	Patient Interview	Yes*	No	
5	Patient Request	No	No	
6	Gross income & number in family.	Yes*	Yes	'76-77 $49,900 '77-78 $54,417

*2E. Hospital 4 - Patient incapable of paying bill and does not meet ability-to-pay scale.

*2E. Hospital 6 - Patient's income falls within ability-to-pay scale.

Hospital	3B. Will you be participating in fiscal 7/1/78 - 6/30/79?	4. Does your hospital receive any local tax assistance?	4A. How much does your current annual mill levy provide? a. operations b. capital projects c. debt retirement a.	b.	c.
1		Yes	3.5 mills/$80,000		
2	No	Yes	3 mills/$129,873		
3	No	Yes		2 mills/$180,000	
4	Yes	Yes		2.03 mills/ $1,275,885	
5	No	No			
6	Yes	Yes	1.52 mills/$105,269		

Hospital	4B. Percent of mill levy generated by property taxes	4C. What percent is this tax of the hospital's total revenue?	4D. Do you receive funds from other local public resources for M. I.?	4E. What are, and how much are, these sources?
1	100%	10%	No	
2	91.70%	37.62%	No	
3	100%		No	
4	100%	8%	Yes	County M.I./$28,000
5	N/A	N/A	N/A	N/A
6		2.5%	No	

County Hospitals Cont'd.
Page 3

Hospital	5. Patients provided M.I. on an annual basis	5A. How many M.I. individuals in your service area?
1	35	Total Population
2	Unkown	Unkown
3	Unkown	
4	1977: Hill-Burton - 207 Hosp. Charity - 142	Unkown
5	N/A	N/A
6	130	Unkown

7. Uncompensated care provided during last accounting year

Hospital	6. Total operating expenses at end of last fiscal year	a. accounting year	b. # of uncompensated care	c. uncompensated care allocated to: i. bad dept	ii. discount	iii. charity	How much charity is M.I.?
1	$449,849/12-31-77	1/1/77 to 12/31/77	.069%			$2,331	All
2	$343,932.04/12-31-77	1/1/77 to 12/31/77	9.18%	$9,510.68	$8,030.35	$1,939.09	All
3	$3,943,459.07	1/1/77 to 12/31/77	.0159%	$109,390.53	$148,124.39	$625.40	
4	$13,258,777/12-31-77	1/1/77 to 12/31/77	7.6%	$301,469.00	$672,220.00	$77,462.00 $13,847.00 (Other)	All
5	$422,119/12-31-77	12/31/76 to 12/31/77	.2%			$87.87	
6	$4,021,661/12-31-77	1/1/77 to 12/31/77	7%	$162,880.00		$128,494.00	

Hospital	8. What ideas or thoughts do you have for the Legislative Committee now reviewing the medically indigent problem?
1	Often patients qualify for charity care but local physicians seeing they cannot collect their fee will send these patients to Denver General. Some provision should be made for the physician fee.
2	It is fiscal irresponsibility to have the Hill-Burton charity requirements in terms of both the expense of administration and the unnecessary loss of revenue. Anything that would foster this philosophy on a State level would be, could be catastrophic.
3	Eliminate the 3% charity factor from the state rules.
4	The 3% charity care requirement is difficult to achieve if the hospital must require evidence of charity need as many patients are not cooperative in providing information and data necessary to qualify a patient for assistance. Not to require this data to qualify a patient for charity care would place an unreasonable burden on other patients who eventually pay for the charity care.
5	No comments made.
6	Have Department of Social Services check income through tax computer. provide more money.

Special District Hospitals

MEDICALLY INDIGENT SURVEY

2A. Meeting free care obligation by:
a. open door policy
b. 3% of oper. expense
c. 10% of orig. amount of loan

Hospital & Bed	2. Hill-Burton Hospital?	a.	b.	c.	2B. Do you interview for ability-to-pay?	2C. Ability-to-pay scale enclosed?
7-38	Yes		x		Yes	Yes
8-43	Yes	None of the above			Yes	Yes
9-32	Yes			x	Yes	Yes
10-40	Yes		x		Yes	No
11-58	Yes	x			Yes	Yes
12-22	Yes		x		Yes	No
13-19	Yes		x		Yes	Yes
14-218	Yes			x	Yes	Yes
15-49	Yes			x	Yes	Yes

Special District Hospitals Cont'd.
Page 2

Hospital	2D. Eligibility for M. I.	2E. Do you have definition for medically indigent?	3. Previous or present participation in M.I. Program?	3A. If so, what years & how much?
7	Using low cost care procedure	Those in need of assistance due to low finances	Yes	'74-75 '75-76
8	Review Committee of 5	No	Yes	FYE 3/31/75 $433.83 2 Patients
9	By income & number of people in family	No	Yes	1976 $419.74
10	Gross income & number of people in family	No	Yes	1974
11	Patient Interview	One who has income enough to live on but nothing left for insurance premiums.	Yes	1976 $3,000 5 Patients
12	Completion of M.I. form and qualifying on scale.	As defined in Colorado M. I. program.	Yes	'77-78 $18,139 48 Patients '76-77 $36,463 75 Patients '75-76 $28,897 124 Patients '74-75 $12,703 50 Patients
13	Qualifying with ability-to-pay scale	No	No	
14	Review Committee	No	No	
15	Completion of M.I. form and qualifying on scale.	No	Yes	'74-75 $15,000 20 Patients '75-76 $7,500 10 Patients

Hospital	3B. Will you be participating in fiscal 7/1/78 - 6/30/79?	4. Does your hospital receive any local tax assistance?	4A. How much does your current annual mill levy provide? a. operations	b. capital projects	c. debt retirement
7	No	Yes		1.367 mills $27,217.00	1.8 mills $36,092.00
8	No	Yes			1.20 mills $21,500.00
9	No	Yes	1.17 mills $75,000.00		1.5 mills $100,000.00
10	No	Yes	1.88 mills $92,441.00		4.46 mills $219,008.00
11	Yes	Yes		.8270 mills $38,764.00	
12	Yes	Yes	2 mills $32,800.00		2.25 mills $30,000.00 + interest
13	No	Yes	2.0 mills $96,019.00		.5 mills $23,966.00
14	No	Yes		1.840 mills $417,651.00	2.25 mills $510,713.00
15	No	Yes			2.6 mills $320,000.00

Hospital	4B. Percent of mill levy generated by property taxes	4C. What percent is this tax of the hospital's total revenue?	4D. Do you receive funds from other local public resources for M. I.?	4E. What are, and how much are, these sources?
7	100%	5%	No	
8			No	
9	83%	8%	No	
10	91%	18.5%	No	
11	100%	1.928%	No	
12	100%	5% Operations/5.5% Bond & Interest	No	
13	100%	8.8%	No	
14	100%	7.240%	No	
15	100%	10%	No	

Hospital	5. Patients provided M.I. on an annual basis	5A. How many M.I. individuals in your service area?
7	38 I.P. 87 O.P.	200
8	25	3,000
9	221	Unkown
10	None	None
11	30	1,500 (Est.)
12	100	30-40% of population
13	18	500
14	217	Unkown
15	20-30	Unkown

Special District Hospitals Cont'd.
Page 5

7. Uncompensated care provided during last accounting year

Hospital	6. Total operating expenses at end of last fiscal year	a. accounting year	b. % of uncompensated care	c. uncompensated care allocated to: i. bad dept	ii. discount	iii. charity	How much charity is M.I.?
7	$1,170,459/3-31-78	4/1/77 to 3/31/78	1.5%	$1,370.00		$16,303.00	$15,974 HB $329 Excess
8	$1,246,883/3-31-78	4/1/77 to 3/31/78	11.56%	$127,431.00	$129,407.00	$10,078.00	All
9	$1,655,250/12-31-77	1/1/77 to 12/31/77	4.8%	$56,947.00	$49,439.00	$80,294.00	No Difference
10		7/1/77 to 12/31/77					
11	$1,831,352/12-31-77	Jan. 1 - Dec. 31		$28,396.00	$204,919.00	$13,375.00	None
12	$552,806.00/12-31-77	1/1/77 to 12/31/77	4.73%	$6,532.00		$17,241.00	Over 95%
13	$918,706/12-31-77	1/1/77 to 12/31/77	4.7%	$30,868.00		$10,600.00	All
14	$10,443,000/12-31-77	1/1/78 to 12/31/78	7.26%	$298,711.00	$405,871.00	$113,994.00	All
15	$2,488,000/12-31-77	1/1/77 to 12/31/77		$89,800.00	$35,307.00	$17,072.00	All

Hospital	8. What ideas or thoughts do you have for the Legislative Committee now reviewing the medically indigent problem?
7	No Comment Made
8	No Comment Made
9	Because of the low amount of monies (5,000) we could receive from the M.I. program, and the requirements (review of stay and audit) we would certainly lose money if we participated. As you can see from our Hill-Burton (80,000) and M.I. (41,000) we have many people who could use the program. The Hill-Burton program was running so high, we made the requirements strictor. Many people who need the help cannot get it now.
10	All payors must pay based on billed changes in accordance with the Colorado Rate Review system to avoid unnecessary duplication of effort and expense and to avoid shifting costs from one payor to another.
11	To include all Colorado Hospitals, not just the metropolitan area.
12	This is the greatest program the State Legislature has ever provided. Nearly 100% of the funds get to where they are really needed. The funding should be expanded to cover the need. We were able to get only about 2/3 of the needed funds for the qualified recipients (after the 3% write-off) for the year 1977-78. Our funding was adequate for 1976-77, which in turn lowered our priority for 1977-78. Without this program this hospital would be in serious financial trouble. We get essentially no county welfare support or help for needy patients coming to us for help.
13	Much more consideration needs to be given to reimbursement for physician services (especially for emergency medical services). This area continues to be a problem for many hospitals.
14	This program is at this time of no value to us. To participate, we would need to raise our charity (indigent) care to about $300,000.
15	1) The difference between the M.I. payment and M.I. Benefit be eligible toward Hill-Burton requirement. 2) Audit requirements be relaxed.

Private Non-Profit & Profit Hospitals

MEDICALLY INDIGENT SURVEY

2A. Meeting free care obligation by:
a. open door policy
b. 3% of oper. expense
c. 10% of orig. amount of loan

Hospital & Bed	2. Hill-Burton Hospital?	2A. a.	2A. b.	2A. c.	2B. Do you interview for ability-to-pay?	2C. Ability-to-pay scale enclosed?
16-328	Yes			x	Yes	No
17-200	No				No	No
18-34	No					
19-37	Yes	x			No	Yes
20-179	Yes	x			Yes	Yes
21-372	Yes			x	Yes	Yes
22-465	No					
23-70	No					
24-80	Yes			x		No
25-26	No					
26-402	Yes			x	Yes	Yes
27-221	Yes			x	Yes	Yes
28-200	*	x			Yes	No
29-572	Yes			x	Yes	No
30-177	No				No	No

*Hospital No. 28, Question 2 - In the past we have received $100,000 of Hill-Burton funds for research purposes only. However, the Colorado Department of Health does not have us listed as a Hill-Burton hospital.

Non-Profit & Profit Hospitals Cont'd.
Page 2

2A. Meeting free care obligation by:
a. open door policy
b. 3% of oper. expense
c. 10% of orig. amount of loan

Hospital & Bed	2. Hill-Burton Hospital?	a.	b.	c.	2B. Do you interview for ability-to-pay?	2C. Ability-to-pay scale enclosed?
31-400	Yes			x	Yes	Yes
32-78	No				No	No
33-20	No				No	No
34-40	Yes			x	Yes	No
35-105	Yes	x			Yes	Yes
36-40	Yes	x			Yes	No
37-50	No				No	No
38-107	Yes	x			Yes	Yes
39-222	Yes	x			Yes	Yes
40-102	Yes	x			Yes	Yes
41-482	Yes			x	Yes	Yes
42-275	No				Yes	No
43-143	Yes	x			Yes	Yes

Hospital	2D. Eligibility for M. I.	2E. Do you have definition for medically indigent?	3. Previous or present participation in M.I. Program?	3A. If so, what years & how much?
16	Based on income & number of children	One who has exhausted all financial resources.	No	
17	N/A	N/A	No	
18	N/A	N/A	No	
19	Based on patient's available income	No	No	
20	No M.I. Program	No	No	
21	Finance Committee Review	Yes*	No	
22	N/A	N/A	No	
23	N/A	N/A	No	
24	Based on family's finances	No	No	
25	N/A	N/A	No	
26	Credit analysis & financial review of patient	Patient unable to afford medical expenses.	No	
27	Completion of M.I. financial form by patient	Yes*	No	

*Hospital No. 21, Question 2E - A patient's inability to meet medical expenses (in full or in part) as determined by the ability-to-pay scale (or perhaps other circumstances) as indicated by an individual patient.

Hospital No. 27, Question 2E - Individuals and/or families who are residents of Colorado that have acquired a place to live, employed or seeking such employment, children enrolled in school whose income falls within the parameters set forth in the Colorado General Hospital Inpatient & Outpatient Ability-to-Pay Scale who are not eligible under the federally assisted programs of Medicare, Medicaid and Champus, or legally entitled to medical benefits under third-party coverage, but whose income is insufficient to pay for necessary medical care and who are confirmed to be eligible by the Department.

Hospital	2D. Eligibility for M. I.	2E. Do you have definition for medically indigent?	3. Previous or present participation in M.I. Program?	3A. If so, what years & how much?
28	Based on financial review of patient	When patient's income is below the U.S. poverty level	No	
29	By application & Patient Interview	No	No	
30	Based on particular circumstances of each case	No	No	
31	Patient Interview	No	No	
32	Based on financial review of patient	No	No	
33	N/A	No	No	
34	Patient Interview	No	No	
35	Patient Interview	When patient's income, based on government's poverty scale, is not sufficient to pay charges.	No	
36	Patient Interview	No	No	
37	Case by case review	No	No	
38	Completion of Below Cost Care Application	No	No	
39	Completion of financial resource form	Limited, or no resource to pay medical bills	No	
40	Use of charity guide-lines	If eligible for charity	No	
41	No third-party coverage, non-alien & income merits	Same as 2D	No	
42	Background of patient	No	No	
43	Completion of application	No (See Application)	No	

Hospital	3B. Will you be participating in fiscal 7/1/78 - 6/30/79?	4. Does your hospital receive any local tax assistance?	4A. How much does your current annual mill levy provide? a. operations b. capital projects c. debt retirement a.	b.	c.
16	No	No			
17	No	No			
18	No	No			
19	No	No			
20	No	No			
21	No	No			
22	No	No			
23	No	No			
24	No	No			
25	No	No			
26	No	No			
27	Yes	No			
28	Yes	No			
29	No	No			
30	No	No			
31	No	No			
32	No	No			
33	No	No			

Hospital	3B. Will you be participating in fiscal 7/1/78 - 6/30/79?	4. Does your hospital receive any local tax assistance?	4A. How much does your current annual mill levy provide? a. operations b. capital projects c. debt retirement a.	b.	c.
34	No	No			
35	Yes	No			
36	No	No			
37	No	No			
38	No	No			
39	Yes	No			
40	Yes	No			
41	No	No			
42	No	No			
43	No	No			

Hospital	4B. Percent of mill levy generated by property taxes	4C. What percent is this tax of the hospital's total revenue?	4D. Do you receive funds from other local public resources for M. I.?	4E. What are, and how much are, these sources?
16 through 43	N/A	N/A	N/A	N/A

Hospital	5. Patients provided M.I. on an annual basis	5A. How many M.I. individuals in your service area?
16	81	Unkown
17	0	Unkown
18	0	Unkown
19	70 I.P. 100 O.P.	5% Est.
20	0	Unkown
21	Not Available	Unkown
22	4,445	Unkown
23	Unkown	Unkown
24	300-400 Est.	Unkown
25	Unkown	Unkown
26	200	1-1/2% Est.
27	1,270 I.P. 8,466 O.P.	Unkown

Hospital	5. Patients provided M.I. on an annual basis	5A. How many M.I. individuals in your service area?
28	500	Unkown
29	23	Unkown
30	Under 50	Unkown
31	616 I.P. 4,735 O.P.	Unkown
32	Unkown	Unkown
33	Unkown	Unkown
34	60	Unkown
35	275 Est.	185 Est.
36	Unkown	Unkown
37	Unkown	Unkown
38	40-50	Unkown
39	1,046 Est.	Unkown
40	Unkown	Unkown
41	234, 1977	Unkown
42	Hundreds	Unkown
43	28, 1977	Unkown

Non-Profit & Profit Hospitals
Cont'd.
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7. Uncompensated care provided during last accounting year

Hospital	6. Total operating expenses at end of last fiscal year	a. accounting year	b. % of uncompensated care	c. uncompensated care allocated to: i. bad dept	ii. discount	iii. charity	How much charity is M.I.?
16	$20,072,322/9-30-77	10/1/76 to 9/30/77	1-9%	$349,253.00	$40,604.00	$76,180.00	All
17	$6,314,119/8-31-77	9/1/76 to 8/31/77	12.1%	$195,023.00	$491,094.00	-0-	
18	$910,161/12-31-77	1/1/77 to 12/31/77	2.99%	$30,658.00	$1,746.00	$762	All
19	$1,659,000/5-31-78	5/31/77 to 5/31/78	5%	$55,175.00	-0-	$33,240.00	All
20	$8,291,147/12-31-77	1/1/77 to 12/31/77	5.2%	$373,817.00	$77,813.00	$80,040.00	None
21	$23,057,150/6-30-78	7/1/77 to 6/30/78	12.2%	$490,282.00	$2,899,059.00	$95,859.00	All
22	$25,655,465/12-31-77	1/1/77 to 12/31/77	4.39%	$225,900.00	$119,614.00	$1,183,013.00	All
23	$3,745,728/6-30-78	7/1/77 to 6/30/78	23.2%	$77,199.00	$1,659.00	$86,614.00	None
24	$5.2 Million/9-30-77	10/1/76 to 9/30/77	3.2%	$21,780.00	$109,690.00	$33,098.00	95%
25	$1,927,488/6-30-78	N/A	N/A	N/A	N/A	N/A	N/A
26	$19,121,940/12-31-77	1/1/77 to 12/31/77	2.5%	$350,793.00	$165,648.00	$57,998.00	$48,672.00

Hospital	6. Total operating expenses at end of last fiscal year	7. Uncompensated care provided during last accounting year: a. accounting year	b. % of uncompensated care	c. uncompensated care allocated to: i. bad dept	ii. discount	iii. charity	How much charity is M.I.?
27	$17,930,403/12-31-77	1/1/77 to 12/31/77	9.48%	$372,942.00	$768,020.00	$1,661,074.00	All
28	$8,499,515/6-30-78 Total hospital patient care costs	6/1/77 to 6/30/78	35%	($425,000.00)		$2,900,000.00	All
29	$34,819,000.00/6-30/78	7/1/77 to 6/30/78	2.8%	$806,000.00	$139,129.00	$143,642.00	$14,455.00
30	$6,726,701.00/12-31-77	1/1/77 to 12/31/77	.2%			$11,496.00	Unkown
31	$24,941,842/3-31-78	4/1/77 to 3/31/78	1.97%			$490,956.00	Unkown
32	$2,244,556/4-30-78	5/1/77 to 4/30/78	5.14%	$115,444.00			Unkown
33	N/A	N/A	N/A	N/A	N/A	N/A	N/A
34	$1,357,926/12-31-77	1/1/77 to 12/31/77	9.8%			$13,330.00	All
35	$5,159,579/6-30-78	6/30/77 to 7/1/78	7%	$168,378.00	$4,790.00	$153,149.00	90%
36	$1,062,111/9-30-77	10/1/76 to 0/30/77	21%	$18,557.00	$198,390.00	$6,803.00	$4,985.00

Non-Profit & Profit Hospitals
Cont'd.
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Hospital	6. Total operating expenses at end of last fiscal year	7. Uncompensated care provided during last accounting year: a. accounting year	b. % of uncompensated care	c. uncompensated care allocated to: i. bad dept	ii. discount	iii. charity	How much charity is M.F.?
37	$1,083,162/9-30-77	10/1/76 to 9/30/77	14.8%	$70,683.00	($49,421.00)		Unkown
38	$4,314,720/12-31-77	1/1/77 to 12/31-77	.0248%	$31,302.00	$60,653.00	$15,392.00	All
39	$14,310,223/5-31-78	6/1/77 to 5/31/78	5.89%	$695.938		$237.976	Unkown
40	$1,530,671/3-31-78	4/1/77 to 3/31/78	13%	$41,995.00	$185,015.00	$8,041.00	All
41	$18,242,080/6-30-78	7/1/77 to 6/30/78	0.82%			$171,829.00	All
42	$11,022,369/6-30-78	7/1/77 to 6/30/78	Unkown			$39,074.00	All
43	$7,554,222/12-31-77	1/1/77 to 12/31/77	Less than 1/2%	N/A	N/A	N/A	N/A

Hospital	8. What ideas or thoughts do you have for the Legislative Committee now reviewing the medically indigent problem?
16	N/A
17	No comment made
18	No comment made
19	As the regulations now read, they seem to be extremely burdensome and expensive regarding the bookkeeping, auditing, record keeping, etc. Additionally, the rate paid cannot exceed Denver General's which does not necessarily relate to the cost of care at our hospital.
20	Adequately fund the MIP program so that it not only will be open to other hospitals, but the participating hospitals' true costs will be met.
21	One of the most pressing problems we are now experiencing (since July 1, 1978) involves those patients who previously qualified under the Spend-Down Program. This program has been discontinued and the result is that there are many patients whose earnings are just high enough to put them over the dollar limitation which would qualify them for assistance. Many such patients are capable of meeting ordinary living expenses but cannot tolerate medical expenses.
22	No comment made
23	No comment made
24	No comment made
25	No comment made
26	The equitable distribution of apportioned funds by the Legislature and regulating agency to ALL health care service providers in the state.
27	There needs to be a better distinction between indigent and "medically indigent". An individual above the ability-to-pay scale guidelines may be medically indigent due to a high level of medical care required for recovery which could make that individual "medically indigent" even though they have third-party coverage (insurance requiring their reimbursement for certain percentage of cost) and are in a certain income bracket.

Hospital	8. What ideas or thoughts do you have for the Legislative Committee now reviewing the medically indigent problem?
28	A broader definition of medically indigent should be used. Also use of the University of Colorado Medical Center's ability-to-pay scale should not be a determining factor for hospital participation. The guidelines are too strict and income dichotomy between partial payment and full payment patients is unrealistic.
29	No comment made
30	No comment made
31	No comment made
32	1) We feel that the 3% stipulation referred to in 8.910.1A is too high. We feel there should be no such stipulation. However, if it is necessary to have such a figure, it should not exceed 1%. 2) To require another audit as stated in 8.920 is entirely an unnecessary expense and is one reason we do not participate. A hospital's fiscal year end audit should suffice. 3) With the Colorado Hospital Commission now in operation, are hospitals allowed to use a sliding payment scale?
33	No comment made
34	The amount of our annual budget is now fixed because of our option of 10% of original grant. But, we have an increased awareness of this in our community, and we do not receive any tax dollars; therefore, the burden placed on the other patients may soon be more than they can pay for.
35	No comment made
36	No comment made
37	No comment made
38	No comment made

Hospital	8. What ideas or thoughts do you have for the Legislative Committee now reviewing the medically indigent problem?
39	Keep the program open to all hospitals in the state. Do not create a mass of paperwork related to the program.
40	Need resources to cover costs - a big problem!!!
41	No comment made
42	Almost all of our indigent 'show-up' in the emergency room. At that point we know we must treat them without compensation. When possible, this hospital pays for the ambulance to take them to Denver. So that all share equally, the money should be distributed to all hospitals based on bed size.
43	Program should be expanded statewide! Advantages: 1. Less expense for the state. 2. Better patient care. Attention to patient's problem more immediate. 3. All citizens have equal access to medical care in their own locality.

COMPILATION OF STATE FUNDED PROGRAMS

FOR SENIOR CITIZENS

	Eligibility (other than age)		FY 73-74	FY 74-75	FY 75-76	FY 76-77	FY 77-78	Notes:
DEPARTMENT OF ADMINISTRATION								
Employees' Emeritus Retirement: [see 24-51-129, -130, -131, C.R.S. 1973; and H.B. 1254, 1978 Session] Supplements the income of retired state employees	PERA coverage prior to 7/1/75; less than $200 monthly retirement benefits; retired prior to 7/1/75 with 20 years service or disability benefits.	Funding: - State	$25,000	$20,000	$65,000	$65,000	$50,000	
		Program Costs: -Direct Services	$17,201	$14,526	$68,405	$53,330	$35,809	
		Clients: - Individuals	45	45	140	135	95	
Annuitants' Health Insurance: [see 10-8-202, -203, C.R.S. 1973] Program provides contribution to retired employees' health insurance at same rate as for regular employees; or at rate of 5% for each year of service	Retirement from state service.	Funding: - State	$235,529	$310,359	$420,172	$629,964	$789,840	
		Program Costs: -Direct Services	$234,473	$317,795	$405,654	$629,479	$668,577	
		Clients: - Individuals	2,700*	2,392	4,113	4,400	4,083	*Estimate
DEPARTMENT OF AGRICULTURE								
Senior Citizen Day at Colorado State Fair		no funding allocated						
DEPARTMENT OF CORRECTIONS								
["no particular activity plan"]								

	Eligibility (other than age)		FY 73-74	FY 74-75	FY 75-76	FY 76-77	FY 77-78	Notes:
DEPARTMENT OF EDUCATION								
Colorado Teacher's Emeritus/ Higher Learning Emeritus Retirement Fund: [see sections 22-64-116 through 120 and sections 23-6-101 through 104 C.R.S. 1973] These funds were created by legislative determination to authorize payments from legislative appropriations to retired teachers who do not receive full coverage from the Public Employees Retirement Association	Teacher's Emeritus: Must have taught at least 20 years in Colorado and retired from teaching in public schools in Colorado prior to July 1, 1973; plus other items in 22-65-116(d-g). Higher Learning Emeritus: Must have taught at least 15 years in Colorado and retired prior to July 1, 1962; plus items in 23-6-101 (2) (b-e).	Funding: -State	$1,406,772	$1,516,667	$1,294,067	$1,449,993	$1,389,634	Assuming no new participants, the program will terminate in 2025.
		Programs: - Administration	$1,106	$1,456	$1,705	$1,810	$1,268	
		- Direct Service	$1,405,666	$1,560,211	$1,292,362	$1,448,183	$1,389,366	
		Clients:	1068	1015	954	867	809	
Senior Citizen Activities in Community School Programs: [see sections 22-32-118 (2) (c), C.R.S. 1973, 1976 Supp]	(See Exhibit 5)							
School Bus Transportation -- Senior Citizens: [see section 22-32-128, C.R.S. 1973]	(See Exhibit 5)							

DEPARTMENT OF HEALTH	Eligibility (other than age)		FY 73-74	FY 74-75	FY 75-76	FY 76-77	FY 77-78	Notes:
Old Age Pensioners Dental Program: [see S.B. 473 (1977); and S.B. 17 (1978)] Provides dentures and denture-related services, oral rehabilitation, x-rays, periodontal treatment, limited restorations	Recipient of Old Age Pension	Funding:						
		- State					$465,270	Program originated in 1977
		Program Costs:						
		- Administration					27,516	
		- Direct Service					444,754	
		Clients:						
		- individuals					1,913	
		- # of services						
		- unserved					28,344*	*Based on number of Old Age Pensioners in Colorado.
Arthritis Control Program: Program aimed at evaluating the arthritis problem and directing consultation to paramedical professionals		Funding:						
		- State					15,000	
		- other					15,000**	**From Arthritis Foundation
		Clients:						
		- # of services					8***	***Clinic workshops
		- unserved					300,000****	****Estimate
High Blood Pressure Control Program: Program designed to reduce morbidity from high blood pressure by screening, detection, referral and follow-up; patient and professional education		Funding:						
		- State				$ 42,000	46,000	State funding terminated 6/30/78
		- Federal			$ 81,000	90,000	105,000	
		Clients:						
		- individuals				3,500	12,000	Unserved aged clients based on estimate extrapolated from figures from National Institute of Health.
		- # of services				7,000	12,000	
		- unserved				118,000	113,000	
Adult Health Maintenance/Well Oldster Program: Department assists 13 organized health departments and 37 rural county public health nursing agencies in developing Well Oldster Programs; program designed to detect early disease conditions and prevent crippling disabilities through health assessment, referral, periodic monitoring, education	Established by local agencies along recommended guidelines	Funding:*						*Funding stated to be from local revenue sharing monies, some through grants under Title III of Older American's Act; no state or federal funds specifically targeted for health maintenance services for elderly.
		Program Costs:**				7,006**		**Estimate of 20% of one nursing consultant in Department of Health for administration; Geriatric Nursing Clinic costs for all administration and services statewide, were $6.01 per clinic visit in FY 75-76, and $6.54 in FY 76-77.
		Clients:						
		- individual	1,398	1,740	4,579	5,394		
		- # of services***	7,904	19,530	51,284	64,718		***Services include clinic visits and screening services.
		- unserved				177,772****		****Unserved population based on estimate of aged, non-institutionalized, oopulation which depends on community resources and services.

DEPARTMENT OF HIGHER EDUCATION	Conditions for Participation			Eligibility		Participation	Notes:
Commission on Higher Education:	Free Tuition	Audit	Credit	Age	Other Requirements	Enrollment	
Adams State 1/	X			65		2 2/	
Aims Community	X		yes	60	Resident of Weld County	80 2/	
Arapahoe Community	X			60			
Colorado Mountain College - Glenwood	X		yes	62		382 2/	
Colorado Mountain College - Leadville	X			62			
Colorado State University	One-Half	yes	yes	60	Minimum Class En-Rollment	600	
Community College of Denver - Auraria	X	yes		65			
Community College of Denver - North	X	only		65		11	
Community College of Denver - Red Rocks	X	yes one per semester		65	Colorado Residency		
Fort Lewis College	X			65			
Loretto Heights (private)	$10.00 per Credit Hour			65			
Mesa College	X			65			
Metropolitan State College	No/Some Partial Pay		yes	62		544	
Morgan Community College	X			55			
Northeastern Jr. College	X			65	Card Issued By School	215	
Northwestern Community College	X	yes	yes	65		1 or 2 per year 2/	
Otero Jr. College	X	only		60		20	

	Conditions for Participation			Eligibility		Participation	Notes:
	Free Tuition	Audit	Credit	Age	Other Requirements	Enrollment	
Pikes Peak Community College	X			60	Classification as 'in state student'		
Trinidad State Jr. College	X	yes		65			
University of Colorado - Boulder	X	only		60	Colorado Resident	190	
University of Colorado - Colorado Springs	X	only		60	Colorado Resident		
University of Colorado - Denver	X	only		60	Colorado Resident	6 2/	
University of Denver (private)	$2.00 Fee	yes		65			Only Continuing Education Classes
University of Northern Colorado	X	only		60	Retired Colorado Resident	2 or 3 per year 2/	
University of Southern Colorado	no	yes		65	Post Retirement		
Western State College	X	yes	yes	60		<100	

1/ Data compiled from responses from the institutions; the Colorado Gerontological Report for 1976, and the National Directory of Educational Programs in Gerontology.

2/ These six institutions were surveyed in October 1978 in order to provide a random sample of enrollment at various state institutions statewide.

DEPARTMENT OF HIGHER EDUCATION (Continued)	Community Service Related	Continuing Education	Gerontology Programs
Special Programs Relating to the Elderly:			
Adams State College			Undergraduate program in sociology, with emphasis in gerontology.
Arapahoe Community College	Classes in limited areas are offered 3 or 4 times per year. Evening classes are offered in cooperation with local school districts.		
Colorado Mountain College		Continuing education courses, some held at local nursing homes.	
Colorado State University	Cooperative Extension Service provides special interest classes.	Courses are available to seniors for a $5.00 fee.	Some individual classes offered.
Community College of Denver - Auraria	Classes for persons interested in working with elderly persons.		Associate degree with emphasis in gerontology.
Community College of Denver - North		Some adult education courses offered.	
Community College of Denver - Red Rocks	Coordination of senior discount program. Several non-credit programs are offered to elderly persons.		
Ft. Lewis College		Courses are offered.	
Loretto Heights			B.A. with a concentration on gerontology
Metropolitan State College	A variety of community programs are offered. One class is devoted to publication of a magazine by seniors -- Scribes. A workshop on legal problems is offered.		
Otero Junior College	RSVP program.		
Pikes Peak Community College		Program designed to meet the needs of elderly persons.	Some courses are offered.
University of Colorado Medical Center			A variety of courses are offered.
University of Denver		One course offered.	
University of Northern Colorado	RSVP program.		BA/MA offered. PhD. of Education in Gerontology

	Eligibility (other than age)		FY 73-74	FY 74-75	FY 75-76	FY 76-77	FY 77-78	Notes:
DEPARTMENT OF HIGHWAYS								
Transportation Services for Elderly and Handicapped: [see Urban Mass Transportation Act of 1964, Section 16 (b) (2); and 43-1-601, C.R.S. 1973] The Urban Mass Transportation Administration, through grants, provides capital assistance to private non-profit organizations to purchase vehicles for transportation of elderly and handicapped.	Person, as defined in act, unable to use mass transportation facilities	Funding:						Program established in 1975
		- State			$ 4,662	$ 5,284	$ 995	Number of services expressed as one-way trips from 7/1/76 to 9/30/76 for FY 75-76 from 10/1/76 to 9/30/77 for FY 76-77; from 10/1/77 to 9/30/78 for FY 77-78
		- Federal			233,097	264,206	9,954	
		- Local			58,275	66,052	2,489	
		Program Costs:						
		- Administration			$ 23,311	$ 26,421	$ 995	
		- Direct service				330,258	12,443	** Current projection for needed service is 9,384 one-way trips per day, based on department's "Specialized Transportation Service Coordination Study", 1978.
		Clients:						
		- # of services			41,634	181,789	172,409*	
		- unserved**						
DEPARTMENT OF INSTITUTIONS								
Community Center Programs [see Exhibit 6]								*Of the total 172,409 in FY 77-78 services, elderly accounted for 91,863 and a yearly average of 87,400 elderly services per year over the course of the program.
Geriatric Treatment Center: (Colorado State Hospital) The center provides specialty treatment to persons age 65 and over through five specialty treatment teams -- diagnostic, behavior therapy, long-term care component, preparation for de-institutionalization, and community-based residential program	Suffering from psychiatric illness, and voluntary commitment	Funding:						
		- State	$3,193,378	$3,305,046	3,553,531	3,337,148	2,943,348	
		- Federal			32,605	4,407	6,533	
		Program Costs:						*Average daily attendance is 148 persons.
		- Administration	$ 153,807	$ 154,647	$ 180,106	$ 189,229	$ 176,353	
		- Direct service	3,039,571	3,150,399	3,406,075	3,142,326	2,773,528	**Services are comprehensive, no mechanism to count these services.
		Clients:						
		- individuals*			526	455	406	***No formal study, or even informal data on unserved individuals; no waiting list and all persons who qualify are admitted.
		- # of services**						
		- unserved***						
Fort Logan Mental Health Center: Services include geriatrics hospital inpatient treatment, two boarding homes, and two aftercare teams	Organic or psychiatric debility	Funding:						Cash is from patient revenue.
		- State	$ 1,039,963	$1,253,757	$1,256,441	$1,098,341	$ 986,510	
		- Federal	48,760	99,488	47,953	14,220	-0-	Administration costs includes allocated services.
		- Cash				455,183	917,950	
		Program Costs:						
		- Administration	$229,676	$420,598	$513,417	$ 424,218	$765,629	Number of services to individual clients and projection of unserved individuals is impossible to compute.
		- Direct service	859,049	932,647	790,977	1,143,520	1,138,831	
		Clients:						
		- individuals				455	406	

	Eligibility (other than age)		FY 73-74	FY 74-75	FY 75-76	FY 76-77	FY 77-78	Notes:
DEPARTMENT OF INSTITUTIONS (Continued)								
Foster Grandparents: The Division of Developmental Disabilities administers this program to give older persons an opportunity to work with hospitalized children and help with their personal needs; the program is sponsored by ACTION	Low-income; good physical and mental health; understanding of children	Funding:						The program originated in 1970-71
		- Federal *						*80%
		- Other **						**20% by participating agency
		Clients:						
		- individuals					93	
DEPARTMENT OF LABOR AND EMPLOYMENT								
Office of Manpower Planning and Development: (no specific programs currently sponsored; in FY 78-79, four Title VII nutrition projects will be provided assistance)								
Displaced Homemaker Program: [see House Bill 1083 (1977)] Provides multi-purpose service centers to older women who become widowed or divorced, and who lack employment skills	Need for displaced homemaker services	Funding:						
		- State					$40,000	
		Program Costs:						
		- Administration					18,000	
		- Direct Services					21,000	
		Clients:						Client data in process of being determined
DEPARTMENT OF LAW (no specific programs)								
DEPARTMENT OF LOCAL AFFAIRS		Funding:						
State Housing Matching Grants: [see 24-32-705 (1) (a), C.R.S. 1973] The Division of Housing administers this program which provides up to a 50% match for the construction, rehabilitation, and acquisition of housing for low-income households, including the elderly	Low-income	- State	$102,000	$252,000	$ 489,400	$ 331,730	$ 530,150	Program originated 7/1/72 Funding reported is for elderly housing units
		- Federal	67,000	333,000	1,525,400	1,777,400	9,283,400	
		- Local	22,500	2,372,000	40,000	3,330	35,600	
		- Other*	18,500	1,810,000	1,995,200	1,614,330	4,916,000	*Private funds
		Program Costs:						
		- Administration	$25,000	$60,000	$50,000	$45,000	$60,000	Administration carried out by personnel conducting direct service activities
		Clients:						
		- individuals	25	497	362	317	1,052	
		- # of services						Number of services: *housing rehabilitation; **new construction.
		*	11	107	144	110	563	
		**	10	307	158	154	314	
		-unserved				49,240	50,350	Projection of unserved clients based on report titled Colorado Households Needing and Qualifying for Housing Assistance, Jan. 1, 1977 to Jan. 1, 1982. March, 1978

DEPARTMENT OF LOCAL AFFAIRS
(Continued)

	Eligibility (other than age)		FY 73-74	FY 74-75	FY 75-76	FY 76-77	FY 77-78	Notes:
Property Tax Exemption [see 39-3-101 (1) (g) (I) (B), C.R.S. 1973] The Division of Property Taxation grants an exemption from property tax to those eligible residents of senior citizen-occupied housing units	Income and asset limitations	Funding: - State* Clients: - # of services**						Program established in 1962 *Funding is for administration of this program and others by the division. **56 housing projects contained 4,099 senior citizen-occupied units which were exempt from taxation.

DEPARTMENT OF MILITARY AFFAIRS
(no specific programs)

DEPARTMENT OF NATURAL RESOURCES

			CY 74	CY 75	CY 76	CY 77	CY 78	
Division of Wildlife: [see 33-4-102 (u), C.R.S. 1973 (1976 Supp)] Senior lifetime fishing and small game license -- $2.00 fee.		Funding: Clients:	2,351	2,434	39,633*	14,551	8,739	No funds are appropriated. Clients expressed as the number of lifetime licenses sold. *Prior to 1976 the fee for this program was $20.00 as authorized in 33-4-102(u) C.R.S. 1973.
Division of Parks and Outdoor Recreation: [see 33-30-103, C.R.S. 1973] The Aspen Leaf Passport is a lifetime permit for free entrance and camping at any state park or recreation area.	Colorado Resident Age eligibility changed from 65 to 64 in 1977)	Funding: Clients:				1,000	1,250	No funds are appropriated. Program originated in 1976. Clients expressed as an approximate number of passes sold.

	Eligibility (other than age)		FY 73-74	FY 74-75	FY 75-76	FY 76-77	FY 77-78	Notes:
DEPARTMENT OF PERSONNEL								
Pre-retirement Seminar: [see 24-50-203, C.R.S. 1973] A seminar is conducted at least quarterly for personnel system employees preparing for retirement; topics include insurance matters, wills, PERA benefits and options, and other related issues	State employee	Funding:						
		Program Costs:						Program not separately financed
		- Administration	$25	$40	$54	$55	$24	Administrative cost is for materials
		- Direct service	367	356	412	585	214	
		Clients:						Number of services expressed as seminar session conducted
		- individuals	168	199	217	182	59	
		- # of services	9	7	7	9	3	
DEPARTMENT OF REGULATORY AGENCIES								
(Insurance Division)								
Assistance to the Elderly in Insurance Matters: [see section 10-11-125, C.R.S. 1973, (1978 Supp.)] This program provides for training of persons to assist elderly persons with their medicare supplemental insurance problems		Funding:						Program originated in 1978
		Clients:						
Disclosure Forms for Medicare Supplemental Insurance Policies: [see sections 10-3-1102 (2.5) and 10-3-1104 (3) C.R.S. 1973, (1978 Supp.)] This program requires disclosure forms to be provided by an insurer to every person purchasing any medicare supplemental policy.		Funding:						Program originated in 1978
		Clients:						
Loss Ratio for Medicare Supplemental Insurance: [see sections 10-8-101 and 10-8-1025 C.R.S. 1973, (1978 Supp.)] Requires all insurers handling and selling medicare supplemental policies must maintain a loss ratio within the acceptable range prescribed by the insurance commissioner		Funding:						Program originated in 1978
		Clients:						

	Eligibility (other than age)		FY 73-74	FY 74-75	FY 75-76	FY 76-77	FY 77-78	Notes:
DEPARTMENT OF REVENUE								
Income tax -- Aged Exemptions		Funding: - State				[$1,939,000]		Funding represents revenue gain had this exemption not been in effect.
		Clients: - individuals				66,045		Individual clients expressed as number of exemptions claimed on returns filed.
Property Tax/Rent Credit: [see 39-22-120 and 121, C.R.S. 1973; see also Exhibit 7] A refund of all or a portion of the property tax paid by elderly or disabled Colorado residents	income limitations	Funding: - State						Program originated in 7/1/71 State Funds are utilized to cover costs of administration of this and other programs
		Program Costs: - Administration						Administrative cost estimated to be $2 per claim filed
		Clients: - individuals - # of services	29,732 $89	40,212 $169	50,402 $199	58,975 $197	69,802 $191	Individual clients expressed as number of claims filed for previous calendar year Number of services expressed as average dollar credit per claim
Retirement Income Exemption: [see Exhibit 8]								
Identification Card for Non-drivers: Cards similar to Colorado drivers licenses issued free to non-drivers age 60 and over; fee of $3.50 if under age 60	Colorado resident and non-driver	Funding: - State						Program for free cards originated in 1975 State funds are utilized to cover costs of administering this and other programs
		Program Cost: - Direct Service	*	*	$6,200	$6,800	$10,800	* For FY 73-74 and FY 74-75 a fee was charged
		Clients: - individuals			2,487	2,718	3,097	

	Eligibility (other than age)		FY 73-74	FY 74-75	FY 75-76	FY 76-77	FY 77-78	Notes:
DEPARTMENT OF SOCIAL SERVICES								
(Food Programs)								
Food Commodities Program: [see Title VII, Older Americans Act and 26-1-109, C.R.S. 1973] The U.S. Department of Agriculture procures surplus food for redistribution through senior nutrition programs	Participants in Title VII Nutrition Project	Funding: - Federal			$98,958	$269,989	$392,583	Federal funds expressed as dollar value of food issued
		Administrative Costs			$34,934	$36,669	$38,396	
		Clients: - individuals			20,525	24,832	30,246	
Food Stamp Program: [see Food Stamp Act of 1964; and 26-1-109, C.R.S. 1973] The U.S. Department of Agriculture program is administered by state and county departments of social services; eligible persons pay none or part of the value of stamps, depending on household income	Old Age Pension recipients are eligible; others must meet USDA income/resource standards	Funding: - Federal	$1,967,594	$3,155,898	$3,669,281	$3,414,954	$3,186,305	Funding is for total state program, including eligibles.
		Clients: - individuals	8,437	10,711	11,247	10,414	9,530	Number of aged clients based on a projection from a national study; number of services expressed as a dollar figure; unserved aged clients is a projection of the number of potentially eligible individuals
		- # of services	$139,882	$262,986	$305,809	$284,506	$262,845	
		- unserved				22,540	22,540	
(Health Services)								
Medicaid [title XIX of Social Security Act, chapter 119, article 5, C.R.S. 1963, as amended] Provides for medical care, drugs, prosthetic devices, and home health care	Old Age Pension recipients	Funding: -Federal				$10,722,610	$11,499,216	
		-State				5,759,114	6,176,247	
						4,963,496	5,322,969	
Nursing Home care		Funding: - Federal				$33,536,728	$36,977,365	
		- State				18,012,576	19,860,543	
						15,524,152	17,116,822	
		Clients: - individuals				34,775	32,049	

DEPARTMENT OF SOCIAL SERVICES
(Continued)

(Income Assistance)	Eligibility (other than age)		FY 73-74	FY 74-75	FY 75-76	FY 76-77	FY 77-78	Notes:
Old Age Pension: [article XXIV, Colorado Constitution, sections 26-2-111 and 26-2-114, C.R.S. 1973]	Financial assistance up to a maximum of $235 per month, less income is provided to those over age 65 by OAP-A. For those ages 60 with 35 years residency in Colorado, OAP-B is available, with the same income requirements.	Funding:						Total funding and number of clients represents all OAP categories
		- Federal	$6,713,393					
		- General Fund	$12,132,067	$12,135,054	$12,529,964	$12,[illegible],100	$12,950,023	
		Clients:						
		- monthly average	26,591	24,936	24,611	22,393	22,056	
Special Needs: [see 26-2-114 (2) (a), C.R.S. 1973, (1978 Supp.)] To provide for special needs of OAP recipients i.e., adult foster care and home care	Old Age Pension Recipient							Program begins July 1, 1979.
(Veterans Affairs)								
Veterans Assistance Program: [see 26-10-101, C.R.S. 1973] Assists veterans and their beneficiaries in securing benefits and entitlements under state and federal law; referral and information; counseling	Veteran of armed forces or a beneficiary.	Funding:						
		- General Fund					$180,923	
		Clients:						
		- individuals	47,206	44,551	41,529	48,599	53,126	
		- # of services	29,327	31,122	31,600	32,865	36,263	

DEPARTMENT OF SOCIAL SERVICES
(Continued)

	Eligibility (other than age)		FY 73-74	FY 74-75	FY 75-76	FY 76-77	FY 77-78	Notes:
Veterans Nursing Home Care: [see Article 12, Title 36, C.R.S. 1973] Provides nursing home care to veterans and to Colorado residents requiring nursing home care in 3 state-owned homes								
Colorado State Veterans Center: Intermediate care facility qualified veterans and dependents are eligible		Funding:						
		- General Fund			$331,340	$360,324	$327,015*	*FY 77-78 funding is an estimate.
		- Cash Funds			369,160	510,797	566,414*	
		Clients:						
		- # of beds			160	160	160	
		(Occupancy percentage)			(87%)	(99%)	(85%)	
Trinidad State Nursing Home: Intermediate and skilled nursing home care		Funding:						
		- Cash Funds			$1,458,962	$1,564,991	$1,674,434*	
		Clients:						
		- # of beds			235	235	235	
		(Occupancy percentage)			(95%)	(94%)	(92%)	
		- patient days			82,095	80,696	79,323	
Colorado State Veterans Nursing Home: Skilled nursing home care open to all qualified veterans or qualified dependents		Funding:						
		- General Funds			$140,551**			**Borrowed from General Fund, repaid at $32,500 for 5 years.
		- Cash Funds			172,461	$789,789	$942,816	
		Clients:						
		- # of Beds			120	120	120	
		(Occupancy percantage)			(44%)	(93%)	(97%)	
		- patient days			9,714***	41,077	42,429	***Did not admint patients until 1/7/76

DEPARTMENT OF SOCIAL SERVICES
(Continued)

	Eligibility (other than age)		FY 73-74	FY 74-75	FY 75-76	FY 76-77	FY 77-78	Notes:
(Vocational Rehabilitation)								
Rehabilitation Services to the Older Blind: [see P.L. 93-112, section 304 (B) (i)] Mobile adjustment team using local resources personnel, provide diagnostic, instructional, counselling and social services to elderly blind persons in 12 rural counties	legally blind;not likely to be eligible for regular state rehabilitation services.	Funding:						Program originated 6/30/74; federal grant terminated 9/30/77, continued with state funding.
		- Federal		$125,000	$125,000	$139,225	$138,029	
		- General Fund						
		- Private Trust		13,888	13,888	13,922		
		Program Costs						
		- Administrative		$29,878	$21,406	$8,477	$14,004	
		- Direct Service		76,240	81,842	81,206	118,585	
		Clients:						*Source for identifying unserved was State Register of Blind Persons.
		- individuals		113	140	184	264	
		- # of services		226	239	371	529	
		- unserved*		186	202	452	2,136**	**Services statewide.
(Division of Services for the Aging)								
State Center Grants [long appropriations bill] Provides various direct services to older persons 60 years of age and older		Funding:						In 1978 the Colorado Commission on the Aging stipulated the use of these funds for assistance to older persons to live independently, such as chore services and homemakers.
		- State	$75,000	$75,000	$100,000	$74,770	$100,000	
		- Federal						
		- Local	25,000	25,000	33,333	24,923	33,333	
		Program Costs:						
		- Direct Service	100,000	100,000	133,333	99,693	133,333	
		Clients: -individuals	8,400	3,400	2,535	32,460		

DEPARTMENT OF SOCIAL SERVICES
(Continued)

	Eligibility (other than age)		FY 73-74	FY 74-75	FY 75-76	FY 76-77	FY 77-78	Notes:
Title III [P.L. 89-73, as amended] Title III of the Older American's Act establishes community services programs administered at the local level by the Area Agencies on Aging. The Area Agencies on Aging in turn grant the allocated funds to service providers for delivery of services such as: transportation, counseling, information and referral, and grocery shopping		Funding: - State - Federal - Local	$67,691 1,409,979 134,100	$92,677 1,392,061 128,159	$93,114 1,213,457 104,652	$146,936 1,429,325 104,526	$132,547 1,151,527 115,778	These programs are administered by the Area Agencies on Aging Local Funding is estimated cash and in kind.
		Program Costs: - Administration - Direct Services	$1,611,770 270,766 1,341,004	$1,686,336 278,140 1,281,598	$1,061,178 260,045 1,046,526	$1,680,787 279,014 1,297,247	$1,399,852 242,074 1,157,778	
		Clients: - # of Services		46,500	60,000 117,754	78,000 140,000	84,000 375,000	
Title V [see Older American's Act, 1965, as amended; P.L. 89-73, as amended] Provides funds for acquiring, or updating existing senior center facilities to serve as multipurpose senior centers to include health, social, educational, and recreational services		Funding: - Federal - Local					$90,667	
		Program Costs: - Direct Services					$90,667	
		Clients: - # of Services					19	The number of services represents the number of Senior Centers served by the funding in 1977-78.
Title VII [see Older Americans Act, 1965, as amended; P.L. 89-73, as amended] Provides one nutritionally sound meal per day to persons 60 years of age and older at no cost [donations are accepted]		Funding: - State - Federal - Local	 $1,321,644 146,849	 $946,856 105,206	 $1,222,237 135,804	 $2,265,500 251,722	 $1,826,800 202,978	Program also offers socialization opportunities and other support services when these are not otherwise provided.
		Program Costs: - Administration - Direct Services	 $1,468,493	 $1,052,062	 $1,358,041	 $2,517,222	 $2,029,778	
		Clients: - # of Services	4,585	7,160	22,224 689,797	29,872 926,872	41,000 1,000,000	
Title IX [see 1975 amendments to the Older Americans Act] Provides for useful, part-time opportunities in community service activities for unemployed, low-income persons at least 55 years old	Minimum income level per individual is $3,140	Funding: - State - Federal - Local					-0- $238,000 27,115	Program was authorized by the 1975 amendments to the Older American's Act for FY 1976
		Clients:					84	

DEPARTMENT OF SCOIAL SERVICES
(Continued)

	Eligibilty (other than age)		FY 77-78	Notes:
Services Provided Through County Departments of Social Service 1/ [see Title XX, Social Security Act]	AFDC, SSI, and without regard to income (Adults and Children needing protection)*			Historical data not available. Data is from the quarterly reports for FY 1977-78, thus number of clients may not represent unduplicated services. And the data only represents 70% of the actual clients served and program costs. *These are the standard eligibility requirements for the Title XX programs and any additional requirements are noted for the various programs.
Day care of a child in his own home or day care facility: care for a portion of a day less than 24 hours including direct care and meals.	Children needing day care	Clients: - individuals*	26	*Number of individuals represents children whose aged parent, or relative substitute is either working or in an education or training program or the family is a single-parent household or one person is incapacitated
		Program Cost:	$6,623	
Education and Training: Services to help secure education and training that will lead to employment. Assistance with costs of training may be provided for one year if all other sources have been utilized.		Clients: - Individuals	80	Of the total education and training services given in the quarter, .004 went to people over 65. 2/
		Program Costs:	$4,329	
Employment Services: Services to assist people to obtain paid or volunteer employment including job counseling, assessment of jobs available in the community and referral to appropriate jobs and follow-up family adjustment counseling.		Clients: - Individuals	35	Of the employment services provided in the quarter surveyed, .007 percent went to people over 65. 2/
		Program Cost:	$1,656	
Family Planning Services: Can be provided to members of households in which the elderly are living and include counseling, education, and medical services to enable individuals to voluntarily to limit their family size.	Other person needing Family planning services	Clients: - Individuals	42	
		Program Cost:	$283	

DEPARTMENT OF SOCIAL SERVICES
(Continued)

	Eligibility (other than age)		FY 77-78	Notes:
Adult foster care: Provision of social services needed to reside in a protected non-medical facility on a 24-hour basis, including screening for referral and continuing evaluation of appropriateness of placement. The costs of basic foster care (housing, food, etc.) are funded through other sources. This service is available only to SSI recipients who are blind or disabled.	SSI/Colorado Supplement under AND or AB	Clients: - individuals	58	15 percent of the persons over 60 received this service in the quarter surveyed. 2/
		Program Cost:	$25,115	
Health Related Services: Services to help people identify and understand their health needs and to utilize necessary medical treatment activities include education and counseling, and facilitation of securing and continuing needed health care.	other persons needing services	Clients: - individuals	3,044	Persons over 65 received 23 percent of total health related services provided in the quarter surveyed. 2/
		Program Costs:	$386,466	
Homemaker Services: Services available in most counties include housekeeping (excluding heavy tasks, such as washing walls or outside windows), personal care (under medical supervision), shopping and food preparation, child care, teaching home management and child care skills and providing transportation for shopping or medical needs when other resources are not available. In some counties homemaker services are purchased by the county for emergency situations only, and are limited to the performance of homemaking tasks and personal care services.		Clients: - individuals	7,139	People over 65 received 61 percent of the total homemaker services provided in the quarter surveyed. 2/
		Program Costs:	$2,498,613	
Home Management: Services including instruction in budgeting, home management, food preparation and nutrition, health and child care, housekeeping and arranging for meal delivery or assistance with housekeeping or meal preparation when necessary.		Clients: - individuals	1,603	Persons over 65 received 40 percent of total home management services provided in the quarter surveyed. 2/
		Program Costs:	$62,017	

DEPARTMENT OF SOCIAL SERVICES
(Continued)

	Eligibility (other than age)	FY 77-78	Notes:
Housing Improvement: Services are directed toward upgrading substandard housing and finding housing or appropriate living arrangements for clients and include: helping to secure household furnishings, working to improve landlord-tenant relations, identifying and working to correct substandard housing conditions and assisting to obtain or retain home ownership.		Clients: - individuals 1,173 Program Costs: $70,022	People over 65 received 39 percent of the total housing improvement services provided in the quarter surveyed. 2/
Transportation Services: Services provided only when transportation is necessary for the provision of another service, and it is not available through other resources. The services for which transportation may be purchased for the recipient are child foster care, education and training, and employment services (job search, on-the-job training and employment counseling). People with Medicaid benefits are eligible to receive transportation to receive medical care, but reimbursement is from Medicaid funds.		Clients: - individuals 1,691 Program Costs: $93,199	Of the total transportation services provided in the quarter surveyed, 18 percent went to recipients over 65.
Assessment of Need for Protection - Adults: Adults needing assistance are identified, investigated, individual situations and service needs diagnosed (includes physical and psychological examinations) and appropriate placement is sought if necessary.		Clients: - individuals 2,095 Program Costs: $213,937	Persons over 65 received 56 percent of the total services provided under this program in the quarter surveyed. 2/
Court Related: Services are provided to aid in the adjudication of adults unable to act in their own behalf and include referral of adults in need of protection from abuse, neglect, or exploitation to courts for hearing and appointment of custodians, voluntary guardians, conservators, or for hearing for commitment.		Clients: - individuals 100 Program Costs: $80,101	.007 percent of this service was received by those over 65 in the quarter surveyed. 2/

DEPARTMENT OF SOCIAL SERVICES
(Continued)

	Eligibility (other than age)		FY 77-78	Notes:
Financial Management: Services to help people become better managers of personal and family finances including the teaching of techniques of budgeting, consumer buying, banking and bill paying and assistance in dealing with creditors, landlords, and with obtaining all available income, including possible tax rebates, etc.		Clients: - individuals	3,176	In the quarter surveyed, persons over 65 received 39 percent of the total financial management services provided. 2/
		Program Costs:	$123,962	
Individual and Family Adjustment Services: A large range of counseling and evaluative services directed toward achieving optimal functioning for an individual in the family or community, or toward protection of adults and children needing protection. Services mainly involve family counseling and negotiation. Group activities to overcome isolation may also be provided, as may needed evaluations of a person in a protective setting (e.g., nursing home).		Clients: - individuals	5,453	Of the services performed under this heading in the quarter surveyed, 11 percent were received by those over 65. 2/
		Program Costs:	$359,320	
Legal Services: Services are provided to assist people in obtaining legal counsel and protection and include assistance in obtaining legal representation in relation to civil or criminal actions (e.g., eviction, divorce) or institutional referral (legal service can be directed at either prevention or facilitation depending on client wishes or needs).		Clients: - individuals	144	Of the legal services provided in the quarter surveyed, .08 percent went to people over 65. 2/
		Program Costs:	$7,652	

DEPARTMENT OF SOCIAL SERVICES
(Continued)

	Eligibility (other than age)		FY 77-78	Notes:
Special Services for the Developmentally Disabled: This service is available to enable developmentally disabled adults and children to remain in the community; to maximize their capability for self-support and self-sufficency; to relieve families from stress, preventing abuse, neglect and exploitation, and to restore family health.		Clients: - individuals	111	Of the services for the Developmentally Disabled those over 65 receiving these represented .06 percent. 2/
		Program Costs:	$161,300	

1/ Data obtained from Colorado Department of Social Services Title XX quarterly reports for FY 77-78 and the Colorado Department of Health's Guide to Major Sources of Governmental Funding for Provision of Health - Related Services to the Elderly.

2/ All percentage figures taken from Colorado Department of Social Services computer report for the first quarter 1978 (January-March 1978) submitted by Charlene J. Birkins.

	Eligibility (other than age)		FY 73-74	FY 74-75	FY 75-76	FY 76-77	FY 77-78	Notes:
DEPARTMENT OF STATE (no programs reported)								
OFFICE OF STATE PLANNING AND BUDGETING								
State-Local Partnerships in Human Services: This is a special human services reform initiative to promote greater effectiveness and efficiency in planning and delivering services by encouraging increased local accountability, decision-making and management; six pilot projects will be implemented to test locally designed innovative systems for service delivery, two of which involve services to seniors: 1) Region 5 -- to develop coordinated fiscal reporting and planning for Title III and Title VII services, and consolidating advisory boards; 2) Region 12 -- to combine administration of Title III and Title VII services; the program is sponsored by the Governor and the Human Services Policy Council		Funding: Program Costs:						Project established May, 1978 Funds are from those currently provided through the Division of Services for the Aging. Project objective is to free administrative funds for direct service costs.
DEPARTMENT OF TREASURY (no programs reported)								

	Eligibility (other than age)		FY 73-74	FY 74-75	FY 75-76	FY 76-77	FY 77-78	Notes:
OFFICE OF THE GOVERNOR								
(Colorado Office of Human Resources)								
Weatherization Program: [see Community Services Act of 1974, Section 222 (a); and Energy Conservation and Production Act, Title IV] Installation of insulation, caulking, storm windows and doors; jointly funded through the Community Services Administration (CSA); and the Department of Energy (DOE), allied services include payment of past due utility bills, consumer education, transportation, and the development of alternative energy	for Community Services Administration programs up to 125% of poverty level; for Department of Energy programs up to 100 % of poverty level.	Funding: - Federal - Local* - Other** Program Costs: - Administration Clients: - individuals		$100,000	$557,000	$419,961	$1,360,000	Program established in 1975 under CSA; DOE program added in 1977. * 20%-40% local match required for CSA programs, match may be waived. ** U.S. Department of Labor, through CETA, provides $1.5 million for manpower services. Program administered by delegate agencies, including community action agencies, councils of governments, and one county council on aging (Gilpin County.) Individual clients for program year estimated at 4,000-5,000; to date, approximately 15,000 persons have received weatherization assistance, 28,000 have been assisted through crisis intervention (specially funded in 1977 and 1978)

Exhibit 5

Senior Citizen Activities in Community School Programs

Senior citizen activities in community school programs are established under the direction of any given board of education. A board of education may conduct a variety of programs as long as they do not interfere with a regular school program. For the purposes of this program senior citizen means a person sixty years of age or older and includes the spouse of a senior citizen. Senior citizen activities may include the availability of the meals regularly served to students at regular mealtimes at a price determined by the board of education of a school district, senior citizen volunteer programs, and utilization of school facilities for senior citizens' activities.

School Bus Transportation -- Senior Citizens

School buses may also be used by senior citizens as specified by the board of education in each school district in the state. This transportation is available to groups of five or more persons over sixty-five years of age.

EXHIBIT 6

Department of Institutions
Community Mental Health Centers - Geriatric Services

Center	#Admissions FY 1975-76	Elderly Population	% of Total	Fiscal Year 1976 - 1977	Admissions	Total Clients Served 1976-77	Estimated # of Admissions Age 60 and Over Fiscal Year 1977-78 Enrolled	Unenrolled	FTE's	# of N.H. Beds
Adams	35	22,000	11.3	33	1%	49	39	7	-	1174
Araphoe	6	11,000	6.5	21	2%	50	55	Unavailable	-	347
Aurora		5,490	3.6	9	1%	16	16	500	-	594
Bethesda	9	14,423	11.5	34	3%	65	19	Unavailable	-	986
Boulder	20	11,395	6.9	22	1%	35	37	120	1	1055
Colorado West	30	14,749	10.0	38	2%	75	27	Unavailable	-	735
Denver	0						2	Unavailable	-	
East Central	1	2,675	12.6	4	1%	4	5	48	-	220
Jefferson	31	25,382	.08	20	2%	132	96	Unavailable	-	2754
Larimer	66	14,921	11	46	2%	56	97	604	4	1243
Midwestern	6	5,884	12.0	29	2%	26	56	Unavailable	1	483
N.E. Colorado	22	8,596	12.7	42	3%	68	37	Unavailable	-	819
N.W. Denver	234	36,565	20	282	3%	465	448	856	-	860
Park East	7			10	1%	19	11	Unavailable	-	807
Pikes Peak	34	23,872	10.4	83	1%	90	172	Unavailable	-	1415
San Luis Valley	19	5,914	9.9	68	7%	88	54	498	2.5	180
Servicios		10,969		20	10%	33	20	Unavailable	-	
S.E. Colorado	4	10,392	17	7	1%	10	15	Unavailable	-	563
S.W. Colorado	4	5,000	10	13	2%	20	49	Unavailable	.4	173
Spanish Peaks	33	23,871	15.7	26	1%	36	74	682	.5	1873
S.W. Denver	15	5,000	5	47	3%	37	89	8	.30	377
Weld	12	10,962	8.8	107	4%	179	73	143	5.1	1018
West Central	3	6,325	.13	14	1%	13	24	Unavailable	-	729

Exhibit 7

OLD AGE PROPERTY TAX CREDIT PROFILE*

Summary Overview By Filing Status, Total All Returns

Status	Number of Filers	Total $ Credit (000)	Average $ Credit	$ 10% Credit	Average Total Credits	Average Amount Property Tax Paid	Average Percent Relief PTC
Married	18,659	3,359	180	22	202	266	68
Single	42,284	8,245	195	14	209	231	84
Married/Disabled	2,595	480	185	17	202	252	73
Single/Disabled	6,264	1,221	195	6	201	212	92
TOTAL	69,802	13,332	191	16	207	240	80

Status	Percent Relief Total PTC + 10%	Average Social Security Income	Average Old Age Pension Income	Average Other Income	Average Total Income	Property Tax As A Percent Of Income
Married	76	3,766	327	1,466	5,559	4.79
Single	90	2,187	188	940	3,315	6.97
Married/Disabled	80	2,923	140	2,220	5,283	4.77
Single/Disabled	95	1,632	62	980	2,674	7.93
TOTAL	86	2,587	212	1,164	3,963	6.06 1/

* Based on a 4.5% sample of returns filed -- 1977 returns filed by June 30, 1978.
Sum of items may not equal totals due to rounding.

1/ Table is taken from Department of Revenue, Research and Statistics
Aged and Disabled Property Tax Relief, Calendar Year 1977 Tax Returns, Table 6, E1.

NOTES: The 1977-78 income thresholds established for the property tax credit are:
up to $3,300 -- single person receives 100% refund of the general property tax or up to 20% of the rent paid by them to occupy a residence
up to $4,300 -- married couple receives 100% refund of the general property tax or up to 20% of the rent paid by them to occupy a residence

The 1977-78 maximum income levels allowable for refunds are:
$7,300 for a single person
$8,300 for a married couple
(Income levels are adjusted annually)

Department of Revenue

The Colorado Department of Revenue has estimated at the 1978 level, the amount of pension and annuity income which would be included in adjusted gross income if such income were subject to Colorado tax. Also included is the appropriate number of returns and the estimated amount of Colorado income tax which would be involved.

Table I shows the tax districution prior to H.B. 1194 (H.B. 1194 does not directly affect the taxation of pension income, but does increase the dollar value of exemptions and adjusts the standard deduction and tax brackets for inflation).

Table II shows the tax distribution after H.B. 1194.

Colorado Department of Revenue
Estimated Distribution of Pension and Annuity Income By
Adjusted Gross Income Classes

Calendar Year 1978

Table 1 - Dollar Amounts in Thousands 1/

Adjusted Gross Income Classes	Number of Returns	Pension and Annuity Income	Colorado Income Tax
Taxable Returns			
Less than $3	262	$ 467	$ 2
3 to 4	1,830	4,620	32
4 to 5	4,151	11,736	111
5 to 6	5,121	17,551	237
6 to 7	5,422	23,276	340
7 to 8	4,238	19,623	308
8 to 9	4,385	23,537	414
9 to 10	4,132	20,706	381
10 to 11	2,822	15,571	301
11 to 12	2,905	17,770	357
12 to 13	2,520	15,266	319
13 to 14	2,218	13,192	284
14 to 15	2,189	12,616	279
15 to 20	8,205	50,117	1,192
20 to 25	4,334	32,404	982
25 to 30	2,320	17,424	1,117
30 to 50	2,888	25,163	936
50 to 100	825	7,901	305
100 and over	217	2,721	99
Total Taxable 2/	61,084	$331,661	$7,996
Non Taxable Returns	14,491	39,740	Ø
Total 2/	75,575	$371,401	$7,996

1/ Estimated amount of pension and annuity income and Colorado income tax if such income were included in Colorado adjusted gross income prior to the provisions of H.B. 1194.

2/ Sum of items may not equal totals due to rounding.

Colorado Department of Revenue
Estimated Distribution of Pension and Annuity Income
By Adjusted Gross Income Classes

Calendar Year 1978

Table 2 - Dollar Amounts in Thousands 1/

Adjusted Gross Income Classes	Number of Returns	Pension and Annuity Income	Colorado Income Tax
Taxable Returns			
Less than $3	262	$ 467	$ 2
3 to 4	1,830	4,620	25
4 to 5	4,151	11,736	89
5 to 6	5,121	17,551	190
6 to 7	5,422	23,276	300
7 to 8	4,238	19,623	273
8 to 9	4,385	23,537	367
9 to 10	4,132	20,706	338
10 to 11	2,822	15,571	266
11 to 12	2,905	17,770	325
12 to 13	2,520	15,266	290
13 to 14	2,318	13,192	257
14 to 15	2,189	12,616	254
15 to 20	8,205	50,117	1,108
20 to 25	4,334	32,404	914
25 to 30	2,320	17,424	565
30 to 50	2,888	25,163	906
50 to 100	825	7,901	298
100 and over	217	2,721	96
Total Taxable 2/	61,084	$331,661	$6,862
Nontaxable Returns	14,491	39,740	Ø
Total 2/	75,575	$371,401	$6,862

1/ Estimated amount of pension and annuity income and Colorado income tax if such income were included in Colorado adjusted gross income after the provisions of H.B. 1194.

2/ Sum of items may not equal totals due to rounding.

COMMITTEE ON HEALTH, ENVIRONMENT,
WELFARE, AND INSTITUTIONS

BILL 47

A BILL FOR AN ACT

PROVIDING FOR STATE REIMBURSEMENT FOR PART OF THE COST OF MEDICAL CARE AND SERVICES RENDERED TO INDIGENT PERSONS, 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.)

Provides that the department of social services reimburse hospitals, health clinics, and physicians providing services through hospitals and health clinics for inpatient medical services and outpatient care rendered to Colorado residents who are within a sliding-fee scale determined annually in the long appropriations bill and by the state board. Such reimbursement shall be as per the annually established formula set by the long appropriations bill and the state board.

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

SECTION 1. Title 26, Colorado Revised Statutes 1973, as amended, is amended BY THE ADDITION OF A NEW ARTICLE to read:

ARTICLE 13

Medical Services Program

26-13-101. Legislative declaration. It is the intent of the general assembly and the purpose of this article to promote the health of the residents of Colorado whose income is

insufficient to meet the costs of necessary medical services by providing state financial assistance to help meet those costs. It is the hope of the general assembly that by utilizing state funds to help meet such costs and expenses, proper and sufficient medical care and service will be available to Colorado residents who otherwise would forego such care due to high costs and low income.

26-13-102. Definitions. As used in this article, unless the context otherwise requires:

(1) "Health provider" means hospitals and health clinics owned and operated by municipalities, counties, and hospital districts and includes private and nonprofit hospitals and licensed physicians providing services through a hospital of the type enumerated above.

(2) "Medical services" means inpatient medical care and outpatient services rendered by a health provider.

(3) "Recipient" means a person whose income, medical expenses, and family size are such that he falls within the allowable parameters of the sliding-fee scale as determined annually in the long appropriations bill and by rule and regulation of the state board.

26-13-103. Reimbursement for medical services. (1) Subject to available funds, the state department shall reimburse a health provider for the cost of medical services rendered by the health provider to a recipient. Such reimbursement shall be in accordance with the reimbursement

formula as determined annually in the long appropriations bill and by rule and regulation of the state board. All health providers seeking reimbursement from the state shall utilize the sliding-fee scale provided for in section 26-13-102 (3). All reimbursements shall be exclusive of any federal reimbursements for medical services and shall be reduced by three percent of all operating expenditures of the health provider.

(2) The state department shall utilize a percentage of available funds, or so much of such percentage amount as may be necessary, to reimburse licensed physicians who are not otherwise paid for medical services rendered to recipients in participating hospitals and health clinics. If such amount is inadequate to fully reimburse each claim for reimbursement, such amount shall be distributed for reimbursement purposes on a per capita basis through participating hospitals and health clinics. The state board shall by rule and regulation determine what percent of available funds shall be utilized for the purpose set forth in this subsection (2).

26-13-104. Rules and regulations. The state board shall adopt rules and regulations necessary to implement this article. Such regulations shall be promulgated and published according to the requirements of article 4 of title 24, C.R.S. 1973.

SECTION 2. Appropriation. There is hereby appropriated, out of any moneys in the state treasury not otherwise appropriated, to the department of social services, for the fiscal year commencing July 1, 1979, the sum of _____ dollars

($), or so much thereof as may be necessary, for the implementation of this act.

SECTION 3. 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.

COMMITTEE ON HEALTH, ENVIRONMENT,
WELFARE, AND INSTITUTIONS

BILL 48

A BILL FOR AN ACT

PROVIDING MEDICAL SERVICES FOR THE MEDICALLY INDIGENT, 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.)

Provides that the department of social services shall establish a statewide medical services program to provide medical services to persons whose medical expenses during the preceding twelve months were at least some percentage of their income for that period, said percentage to be determined by said department which is authorized to provide different percentages for different levels of income. Such eligible persons shall then participate with the state in a copayment scheme for further medical expenses. Provides that such medical services be provided by local providers which are designated by the state board of social services on the basis of cost and quality.

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

SECTION 1. Title 26, Colorado Revised Statutes 1973, as amended, is amended BY THE ADDITION OF A NEW ARTICLE to read:

ARTICLE 13

Medical Services Program

26-13-101. Legislative declaration. It is the intent of the general assembly and the purpose of this article to promote

and improve the health and welfare of the residents of Colorado whose medical expenses require the expenditure of a large percentage of their income to meet such expenses, as such percentage is determined by the state department and subject to the availability of funds. It is further the intent of the general assembly that the assistance program established in this article provide relief and necessary medical services at locations which are convenient to and in close proximity to such residents. It is intended that the scope of the assistance program established in this article be within the availability of funds and be limited to those medical services given top priority by the state board of social services when such funds are inadequate to cover each and every medical service.

26-13-102. Definitions. As used in this article, unless the context otherwise requires:

(1) "Health maintenance organization" means a public or private organization organized under the laws of this state which provides or otherwise makes available to enrolled participants health care services, including at least usual physicians' services, hospitalization, laboratory, X-ray, emergency and preventive services, and out-of-area coverage; is compensated, except for copayments, for the provision of the basic health care services specified in this subsection (1) by enrolled participants on a predetermined periodic rate basis; and provides physicians' services primarily directly through physicians who are either employees or partners of such organization or through

arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis.

(2) "Health provider" means private or public general hospitals and community clinics, provided said health providers are licensed by the state of Colorado, and includes private physicians licensed by the state of Colorado, free standing kidney dialysis centers, and health maintenance organizations.

(3) "Health service area" means an area designated by the secretary of health, education, and welfare pursuant to section 1511 of the federal "Public Health Service Act", as amended, 42 U.S.C. 210 et seq.

(4) "Medical services" means services rendered by a health provider to persons eligible for such services pursuant to this article and rules and regulations of the department, which services are rendered for the necessary medical care of such persons.

26-13-103. Medical services program. (1) The state board shall establish, by rule and regulation, a program for medical providers to provide medical services to those Colorado residents who are eligible for such services. Such program shall not be inconsistent with the provisions of this article.

(2) (a) Eligibility requirements shall be established by the state board but shall be based on the requirement that a percentage of the person's family income for the immediately preceding twelve months shall have been expended on medical

expenses incurred within such period. The determination of eligibility shall further be based upon proof of family income by means of Colorado income tax returns covering such period and proof of medical expenses by means of bills or written charges for such expenses, both of which shall be provided by the person seeking assistance under the program. The state board shall determine by rule and regulation the percentage required in this subsection (2) and may provide for different percentages for different levels of income.

(b) "Family income", for the purposes of this subsection (2), means all income received by a family during a calendar year, regardless of source or tax status, including but not limited to social security and retirement benefits, interest, dividends, total gain from the sale or exchange of a capital asset, net rental income, salary or earnings, net income from self-employment, and inheritances, but the term shall not include a return of capital.

(3) A person who qualifies under subsection (2) of this section and the rules and regulations pursuant thereto shall receive assistance according to the program's copayment schedule which shall be established by the state board by rule and regulation. Subject to the availability of funds, the state department shall pay the state's portion of the cost of the services according to the schedule up to a maximum amount of _____.

(4) (a) Any state funds as are appropriated from year to

year to the state department for implementation of the program provided for in this article shall be distributed as provided in this section.

(b) The state board shall designate by rule and regulation such providers in each health service area which shall be the providers of medical services under the program in the health service area in which they are located. Such designation shall be on the basis of the cost and the quality of the service to be provided.

(c) The state board shall allocate, pursuant to such rules and regulations as are promulgated by the state board, the appropriated funds to the designated providers.

SECTION 2. Appropriation. There is hereby appropriated, out of any moneys in the state treasury not otherwise appropriated, to the department of social services, for the fiscal year commencing July 1, 1979, the sum of _____ dollars ($), or so much thereof as may be necessary, for the implementation of this act.

SECTION 3. 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.

COMMITTEE ON HEALTH, ENVIRONMENT
WELFARE, AND INSTITUTIONS

BILL 49

A BILL FOR AN ACT

CONCERNING A MEDICAL ASSISTANCE PROGRAM FOR HANDICAPPED CHILDREN AND MEDICALLY INDIGENT PERSONS, 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.)

Provides that the department of health shall receive and administer federal and state funds for a program which reimburses health providers rendering medical services and care to handicapped children and medically indigent persons. Provides for contracting between the department and any health provider, including private physicians and health maintenance organizations, for such services and care. Eligibility is based on an ability-to-pay scale. Reimbursement rates are set by negotiation or the current medicare reimbursement schedule under Title XVIII of the federal "Social Security Act"; except that hospital rates shall be set by the Colorado hospital commission.

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

SECTION 1. Title 25, Colorado Revised Statutes 1973, as amended, is amended BY THE ADDITION OF A NEW ARTICLE to read:

Article 22

Medical Services Program

25-22-101. Legislative declaration. It is the purpose of

this article to promote the public health and welfare of the people of Colorado by aiding handicapped children and medically indigent persons to obtain needed medical care and services. It is the intent and goal of this article to achieve this end by providing a wide range of services and care in every area of the state by encouraging the department of health to contract for services in such a way that geographic accessibility is assured. It is the further intent of the general assembly that contracts for such services and care be available to all potential providers and that such contracts be given to those providing services and care at the lowest rate possible.

25-22-102. Definitions. As used in this article, unless the context otherwise requires:

(1) "Department" means the department of health.

(2) "Health provider" means a person, agency, or business concern providing medical care and treatment, occupational, physical, and speech therapy, orthodontic care, public health nursing service, hearing service, social services, and medical and rehabilitative goods, and "health provider" includes licensed physicians, dentists, podiatrists, optometrists, hospitals, and health maintenance organizations.

25-22-103. Services - contracts. (1) The department shall be the recipient of such state and federal funds as may be appropriated for the administration of the program for services and care to the needy handicapped children and the medically indigent. The department shall contract with health providers

for the provision of services and care to persons eligible under the program. The department shall attempt to contract with those health providers offering services and care at the lowest cost and shall attempt to secure contracts in all areas of the state in order that as wide a variety of services and care as possible will be available in each area. The department shall reimburse health providers according to rules and regulations promulgated by the department but not inconsistent with this article.

(2) For contract and reimbursement purposes, the department is hereby authorized to establish a system of priorities of services and care. Contracts and reimbursements shall be made according to said system. Any system so established shall emphasize perinatal and child care.

(3) No reimbursement shall be made to a hospital unless the hospital has provided at least _____ percent of its total services and care free of charge to persons eligible under the program.

(4) In the case of services and care provided by a physician to medically indigent persons, the department shall provide for an assignment process whereby such services and care are guaranteed to such eligible medically indigent persons with the assurance there will be no charge made later to such person for the services and care.

25-22-104. Eligibility. The department shall establish, by rule and regulation, eligibility criteria for participation in the program. Such criteria shall be based upon an ability-to-pay

scale which shall be established by the department.

25-22-105. Reimbursement. (1) Subject to the availability of funds, reimbursement under the program shall be at the 1978-1979 fiscal year rate for the medicare reimbursement schedule under Title XVIII of the federal "Social Security Act", as amended, or at a rate set by the department by negotiation with health providers; except that, hospitals shall be reimbursed at a rate which is approved by the Colorado hospital commission.

(2) The department is authorized to allow health providers to forestall the rendering of services and care of a nonemergency nature until the commencement of the following fiscal year. Such authority shall only be exercised when, in the opinion of the department, funds are at such a level that necessary and essential services and care cannot be rendered to a reasonably large amount of people for the remainder of the fiscal year.

(3) The department shall promulgate rules and regulations to implement this section.

SECTION 2. Appropriation. There is hereby appropriated, out of any moneys in the state treasury not otherwise appropriated, to the department of health, for the fiscal year commencing July 1, 1979, the sum of _____ dollars ($), or so much thereof as may be necessary, for the implementation of this act.

SECTION 3. 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.

COMMITTEE ON HEALTH, ENVIRONMENT,
WELFARE, AND INSTITUTIONS

BILL 50

A BILL FOR AN ACT

CONCERNING PLACEMENT OF CHILDREN ADJUDICATED TO BE NEGLECTED OR DEPENDENT OR NEEDING OVERSIGHT OR DELINQUENT.

Bill Summary

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

Provides that courts may place legal custody of a child in the county department of social services or a child placement agency for permanent placement in a child care center or family care home. Requires that such centers be licensed by the department of social services and that such homes be located in Colorado.

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

SECTION 1. 19-1-103 (4) and (14), Colorado Revised Statutes 1973, 1978 Repl. Vol., are amended to read:

19-1-103. Definitions. (4) "Child care center" means a facility licensed and approved pursuant to law BY THE COLORADO DEPARTMENT OF SOCIAL SERVICES. ~~If such facility is located in another state, it shall be licensed or approved as required by law in that state.~~

(14) "Family care home" means a facility licensed and approved pursuant to law AND LOCATED WITHIN THE STATE OF

COLORADO. ~~If such facility is located in another state, it shall be licensed or approved as required by law in that state.~~

SECTION 2. 19-3-111 (1)(c), Colorado Revised Statutes 1973, 1978 Repl. Vol., is amended to read:

19-3-111. Neglected or dependent child - disposition. (1) (c) The court may place legal custody in the county department of social services or a child placement agency for placement in a family care home or ~~other~~ A child care ~~facility~~ CENTER, AND SUCH CUSTODY SHALL BE UNCONDITIONAL.

SECTION 3. 19-3-112 (1)(d), Colorado Revised Statutes 1973, 1978 Repl. Vol., is amended to read:

19-3-112. Child needing oversight - disposition. (1) (d) The court may place legal custody in the county department of social services or a child placement agency for placement in a family care home or ~~child care facility, or it may place the child in~~ a child care center, AND SUCH CUSTODY SHALL BE UNCONDITIONAL.

SECTION 4. 19-3-113 (3)(d), Colorado Revised Statutes 1973, 1978 Repl. Vol., as amended, is amended to read:

19-3-113. Delinquent child - disposition. (3) (d) The court may place legal custody in the county department of social services or a child placement agency for placement in a family care home or ~~child care facility, or it may place the child in~~ a child care center, AND SUCH CUSTODY SHALL BE UNCONDITIONAL.

SECTION 5. Effective date. (1) Section 4 of this act shall take effect July 1, 1979, subject to the following conditions

having been met:

(a) The department of social services has developed a plan for the provision of shelter care and other services necessary for the implementation of S. B. 101, Session Laws of Colorado 1978, and said plan and any request for funds have been submitted for consideration by the joint budget committee no later than February 1, 1979; and

(b) The provision of adequate funds has been made in the general appropriation bill to fund said plan.

(2) The remainder of this act shall take effect upon passage of this act.

SECTION 6. 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.

COMMITTEE ON HEALTH, ENVIRONMENT, WELFARE, AND INSTITUTIONS

BILL 51

A BILL FOR AN ACT

CONCERNING PLACEMENT OF CHILDREN PURSUANT TO THE CHILDREN'S CODE, AND ESTABLISHING MULTIDISCIPLINARY ASSESSMENT UNITS THEREFOR.

Bill Summary

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

Provides that children shall be placed in child care centers licensed and approved by the Colorado department of social services and located in Colorado. Allows children to be sent to out-of-state facilities approved by the department if adequate in-state facilities are not available. Provides for an assessment and placement study to be made by a multidisciplinary unit. Allows a county department of social services to make placement to such facility as the unit determines, based on its recommendations, will best serve the needs of the child.

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

SECTION 1. 19-1-102 (1), Colorado Revised Statutes 1973, 1978 Repl. Vol., is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

19-1-102. Legislative declaration. (1) (e) To ensure that any child removed from the custody of his parents and placed in a child care center shall be placed only in a facility located in

Colorado and approved and licensed by the department of social services. Should an adequate treatment facility be unavailable in Colorado, out-of-state placement may be permitted in facilities approved by the said department.

SECTION 2. 19-1-103 (4), (14), and (15), Colorado Revised Statutes 1973, 1978 Repl. Vol., are amended to read:

19-1-103. Definitions. (4) "Child care center" means a facility licensed and approved pursuant to law. If such facility is located in another state, it shall be licensed or approved as required by law in that state AND SHALL BE APPROVED BY THE COLORADO DEPARTMENT OF SOCIAL SERVICES.

(14) "Family care home" means a facility licensed and approved pursuant to law. If such facility is located in another state, it shall be licensed or approved as required by law in that state AND SHALL BE APPROVED BY THE COLORADO DEPARTMENT OF SOCIAL SERVICES.

(15) "Group care facilities and homes" means places other than foster family care homes providing care for small groups of children. IF SUCH FACILITIES ARE LOCATED IN ANOTHER STATE, THEY SHALL BE LICENSED OR APPROVED AS REQUIRED BY LAW IN THAT STATE.

SECTION 3. 19-3-111 (1) (c), Colorado Revised Statutes 1973, 1978 Repl. Vol., is amended to read:

19-3-111. Neglected or dependent child - disposition. (1) (c) The court may place legal custody in the county department of social services ~~or a child placement agency~~ for placement ~~in a family care home, or other child care facility~~ OF

THE CHILD, SUCH PLACEMENT TO BE DETERMINED BY THE COUNTY DEPARTMENT PURSUANT TO ARTICLE 3.5 OF THIS TITLE.

SECTION 4. 19-3-112 (1) (d), Colorado Revised Statutes 1973, 1978 Repl. Vol., is amended to read:

19-3-112. Child in need of supervision - disposition. (1) (d) The court may place legal custody in the county department of social services ~~or-a--child--placement--agency~~ for placement ~~in-a-family-care-home-or-child-care-facility;-or-it-may place--the--child--in--a--child--care--center~~ OF THE CHILD, SUCH PLACEMENT TO BE DETERMINED BY THE COUNTY DEPARTMENT PURSUANT TO ARTICLE 3.5 THIS TITLE.

SECTION 5. 19-3-113 (3) (d), Colorado Revised Statutes 1973, 1978 Repl. Vol., as amended, is amended to read:

19-3-113. Delinquent child - disposition. (3) (d) The court may place legal custody in the county department of social services ~~or-a-child-placement-agency~~ for placement ~~in--a--family care--home-or-child-care-facility;-or-it-may-place-the-child-in-a child-care-center~~ OF THE CHILD, SUCH PLACEMENT TO BE DETERMINED BY THE COUNTY DEPARTMENT PURSUANT TO ARTICLE 3.5 OF THIS TITLE.

SECTION 6. 19-3-115 (3) (a), Colorado Revised Statutes 1973, 1978 Repl. Vol., is amended to read:

19-3-115. Legal custody - guardianship. (3) (a) Any agency other than the department of institutions vested by the court with legal custody of a child shall have the right, subject to the approval of the court, to determine where and with whom the child shall live. HOWEVER, NO COURT APPROVAL SHALL BE

NECESSARY WHEN LEGAL CUSTODY IS WITH THE COUNTY DEPARTMENT OF SOCIAL SERVICES PURSUANT TO SECTION 19-3-111, 19-3-112, OR 19-3-113 FOR PLACEMENT AS PROVIDED IN ARTICLE 3.5 OF THIS TITLE.

SECTION 7. Title 19, Colorado Revised Statutes 1973, 1978 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW ARTICLE to read:

ARTICLE 3.5

Multidisciplinary Assessment Units

19-3.5-101. Children committed to the county department of social services. When legal custody of a child is committed by the juvenile court to the county department of social services pursuant to section 19-3-111, 19-3-112, or 19-3-113, a diagnostic evaluation and placement study shall be made by a multidisciplinary assessment unit, and upon completion of such study the county department of social services shall order placement of the child to a facility approved by the Colorado department of social services which in the opinion of the unit will best serve the needs of that child.

19-3.5-102. Diagnostic evaluation and placement study - multidisciplinary assessment unit. (1) A diagnostic evaluation and placement study shall be conducted by a team known as a multidisciplinary assessment unit, consisting, where possible, of a physician; an attorney; representatives of a local law enforcement agency, the juvenile court, the county department of social services, a local mental health clinic, the public health department, and a public school district; and one or more

representatives of the lay community.

(2) The director of the county department of social services shall appoint a representative recommended by a local law enforcement agency, and a person shall be assigned by the presiding judge of the juvenile court serving the county. All other members shall be appointed by the director of the county department of social services. All members shall serve at the pleasure of such director.

(3) It is the intent of the general assembly to encourage the creation of one or more multidisciplinary assessment units in each county or group of continguous counties. In each county in which custody of ____ or more children is committed by the juvenile court to the county department of social services the director of the county department shall cause a unit to be inaugurated in the next following year.

(4) Such units shall be established by and within the local county department of social services, and the administration of its duties shall be governed by the rules and regulations of the state department of social services.

(5) A diagnostic evaluation and placement study shall include but not be limited to information of a professional nature such as psychological evaluations, social histories, and medical reports, and this information shall be shared by the members of the multidisciplinary unit, to prevent duplication of services within the unit.

SECTION 8. Appropriation. In addition to any other

appropriation, there is hereby appropriated, out of any moneys in the state treasury not otherwise appropriated, to the department of social services for allocation to county departments of social services, for the fiscal year commencing July 1, 1979, the sum of _____ dollars ($), or so much thereof as may be necessary, for the implementation of this act.

SECTION 9. Effective date. (1) Section 5 of this act shall take effect July 1, 1979, subject to the following conditions having been met:

(a) The department of social services has developed a plan for the provision of shelter care and other services necessary for the implementation of S. B. 101, Session Laws of Colorado 1978, and said plan and any request for funds have been submitted for consideration by the joint budget committee no later than February 1, 1979; and

(b) The provision of adequate funds has been made in the general appropriation bill to fund said plan.

(2) The remainder of this act shall take effect upon passage of this act.

SECTION 10. 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.

COMMITTEE ON HEALTH, ENVIRONMENT,
WELFARE, AND INSTITUTIONS

BILL 52

A BILL FOR AN ACT

CONCERNING COMMUNITY MENTAL HEALTH CENTERS AND CLINICS.

Bill Summary

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

Provides for including services rendered by community mental health centers and clinics in with other services which are reimbursed under the "Colorado Medical Assistance Act". Provides that community mental health clinics and centers be licensed by the department of institutions rather than the department of health.

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

SECTION 1. 26-4-103, Colorado Revised Statutes 1973, as amended, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

26-4-103. Definitions. (2.5) "Clinic services" means preventative diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to outpatients by or under the direction of a physician in a facility which is not part of a hospital but which is organized and operated to provide medical care to outpatients and which is a community mental health center licensed by the Colorado department of institutions pursuant to article 1 of title 27, C.R.S. 1973.

SECTION 2. 26-4-105 (1), Colorado Revised Statutes 1973, as amended, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

26-4-105. Basic services for categorically needy. (1) (m) Clinic services.

SECTION 3. 25-1-107 (1) (l) (I), Colorado Revised Statutes 1973, as amended, is amended to read:

25-1-107. Powers and duties of the department. (1) (l) (I) To annually license and to establish and enforce standards for the operation of general hospitals, psychiatric hospitals, community clinics, rehabilitation centers, convalescent centers, ~~community-mental-health-centers;~~ facilities for the mentally retarded, habilitation centers for brain-damaged children, chiropractic centers and hospitals, maternity hospitals, nursing care facilities, intermediate care facilities, residential care facilities, the pilot project rehabilitative nursing facility, and other institutions of a like nature, except those wholly owned and operated by any governmental unit or agency. In establishing and enforcing such standards and in addition to the required announced inspections, the department shall, within available appropriations, make additional inspections without prior notice to the facility. Such inspections shall be made only during the hours of 7 a.m. to 7 p.m. The issuance, suspension, renewal, revocation, annulment, or modification of licenses shall be governed by the provisions of sections 24-4-104, C.R.S. 1973, and 25-3-102, and all licenses shall bear the date of issue and cover a twelve-month period.

Nothing contained in this paragraph (1) shall be construed to prevent the department from adopting and enforcing, with respect to projects for which federal assistance has been obtained or shall be requested, such higher standards as may be required by applicable federal laws or regulations of federal agencies responsible for the administration of such federal laws.

SECTION 4. 27-1-103 (1), Colorado Revised Statutes 1973, as amended, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

27-1-103. Duties of executive director - governor acquire water rights. (1) (k) To annually license community mental health centers, as defined in section 27-1-109.

SECTION 5. Part 1 of article 1 of title 27, Colorado Revised Statutes 1973, as amended, is amended BY THE ADDITION OF THE FOLLOWING NEW SECTIONS to read:

27-1-109. Community mental health centers - license - application - issuance - fees. (1) No person shall operate a community mental health center without first being licensed to operate such a center by the department of institutions.

(2) An application for such license shall be made to the department of institutions upon such form and in such manner as prescribed by said department. The department of institutions has authority to administer oaths, subpoena witnesses, and take testimony in all matters relating to issuing, refusing, or revoking such license. The department shall issue licenses to applicants furnishing satisfactory evidence of fitness to conduct and maintain such institution in accordance with the standards

and rules and regulations adopted by said department. Such license shall expire one year after the date of issuance.

(3) For the purposes of this part 1, "community mental health center" includes the term "community mental health clinic" and means such facilities as are defined in section 27-1-201, C.R.S. 1973.

27-1-110. Standards. (1) The department of institutions shall prescribe and publish minimum standards for licensing of community mental health centers. Such standards shall be established by rule of the department, and such rules shall be issued and published only in conformity with the provisions and procedures specified in article 4 of title 24, C.R.S. 1973, and shall become effective only as provided in said article 4.

27-1-111. License denial or revocation. (1) Application for a new or renewal license for a community mental health center as provided for in section 27-1-109 may be refused to an applicant not meeting the requirements of said section and the rules and regulations of the department of institutions. A license may be revoked for like reasons.

(2) No denial of a renewal license shall be lawful unless, before institution of such proceedings by the department of institutions, said department has given the licensee notice in writing of facts on conduct that may warrant denial, has afforded the applicant opportunity to submit written data, views, and arguments with respect to such facts on conduct, and, except in cases of deliberate and willful violation, has given the

applicant a reasonable opportunity to comply with all lawful requirements for licensure.

(3) No application for renewal of a license shall be denied by the department of institutions and no previously issued license shall be revoked, suspended, annulled, limited, or modified until after a hearing as provided in section 24-4-105, C.R.S. 1973.

SECTION 6. 25-3-101, Colorado Revised Statutes 1973, as amended, is amended to read:

25-3-101. Hospitals - licensed. It is unlawful for any person, partnership, association, or corporation to open, conduct, or maintain any general hospital, psychiatric hospital, community clinic, rehabilitation center, convalescent center, ~~community--mental--health--center;~~ facility for the mentally retarded, habilitation center for brain-damaged children, chiropractic center, chiropractic hospital, maternity hospital, nursing care facility, intermediate care facility, residential care facility, pilot project rehabilitative nursing facility, or other institution of a like nature, except those wholly owned and operated by any governmental unit or agency, without first having obtained a license therefor from the department of health.

SECTION 7. Repeal. 25-1-107 (1) (l) (III), Colorado Revised Statutes 1973, is repealed.

SECTION 8. 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.

COMMITTEE ON HEALTH, ENVIRONMENT,
WELFARE, AND INSTITUTIONS

BILL 53

A BILL FOR AN ACT

CONCERNING ALTERNATIVES TO LONG-TERM NURSING HOME CARE FOR OLDER PERSONS, AND RELATING TO APPROPRIATIONS FOR PROVISION OF SUCH SERVICES.

Bill Summary

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

Provides alternatives to institutionalization of impaired older persons by means of providing necessary health and social services in the home for the determined eligible. Places administration and service delivery responsibilities on each county, and seeks title XIX medicaid funds for reimbursement for such services.

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

SECTION 1. Article 11 of title 30, Colorado Revised Statutes 1973, 1977 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW PART to read:

PART 7

ALTERNATIVES TO LONG-TERM NURSING HOME CARE

30-11-701. Short title. This part 7 shall be known and may be cited as the "Alternatives to Long-Term Nursing Home Care Act".

30-11-702. Legislative declaration. (1) The general assembly hereby finds and declares that it is the purpose of this part 7 to establish pilot projects which would develop information about effective methods:

(a) To prevent premature disengagement of older persons from their home communities and subsequent commitment to institutions;

(b) To provide optimum accessibility to various important community social and health resources available to assist active older persons in maintaining independent living;

(c) To provide that the moderately impaired or frail older person who has the capacity to remain in an independent living situation has access to the appropriate social and health services without which independent living would not be possible;

(d) To provide the most efficient and effective use of public funds in the delivery of these social and health services;

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

(f) To allow the state substantial flexibility in organizing or administering the delivery of social and health services to its older persons.

30-11-703. Definitions. As used in this part 7, unless the context otherwise requires:

(1) "Commission" means the commission on home care services established in each county of the state.

(2) "Department" means the department of social services.

(3) "Home care services" means one or more of the following services provided to older persons at home:

(a) Those services provided by a home care services agency;

(b) Home health aid services;

(c) Personal care services;

(d) Homemaker services;

(e) Housekeeper or chore services.

(4) "Home care services agency" means an organization primarily engaged in arranging and providing directly or through contract arrangement one or more of the following: Nursing services, home health aide services, and other therapeutic and related services which may include, but shall not be limited to, physical, speech and occupational therapy, nutritional services, medical social services, personal care services, homemaker services, and housekeeping or chore services, which may be of a preventive, therapeutic, rehabilitative, health guidance, and supportive nature to older persons at home.

(5) "Home health aide services" means simple health care tasks, personal hygiene services, housekeeping tasks essential to the older person's health, and other related supportive services. Such services shall be prescribed by a physician in accordance with a plan of treatment for the patient and shall be under the supervision of a registered professional nurse from a certified home health agency or, when appropriate, from a provider of a long-term home health care program and of the appropriate

professional therapist from such agency or provider when the aide carries out simple procedures as an extension of physical, speech, or occupational therapy.

(6) "Homemaker services" means assistance and instruction in managing and maintaining a household, dressing, feeding, and incidential household tasks for older persons at home because of illness, incapacity, or the absence of a caretaker relative. Such services shall be provided by persons who meet the standards established by the department.

(7) "Housekeeper services" or "chore services" means the provision of light work or household tasks which do not require the services of a trained homemaker. Such services may be provided for older persons at home because of illness, incapacity, or the absence of a caretaker relative by persons who meet the standards established by the department.

(8) "Long-term home health care program" means a coordinated plan of care and services provided at home to invalid, infirm, or disabled older persons who would require placement in a hospital or residential health care facility for an extended period of time if such program were unavailable. Such program shall be provided in the person's home or in the home of a responsible relative or other responsible adult.

(9) "Older person" means a person fifty-five years of age or older.

(10) "Personal care services" means services to assist with personal hygiene, dressing, feeding, and household tasks

essential to the older person's health. Such services shall be prescribed by a physician in accordance with a plan of home care supervised by a registered professional nurse.

30-11-704. Administration. (1) The provisions of this part 7 shall be administered by the department.

(2) The department shall designate the board of county commissioners from the several counties of the state to implement the provisions of this part 7.

30-11-705. Commission created. (1) There is hereby established in each county of the state a commission on home care services, which shall consist of five members, selected and appointed by the respective boards of county commissioners, for terms of four years.

(2) Such commission shall be composed of a physician, a nurse, a social worker, and two members of the local community.

(3) Appointments to fill vacancies shall be for the unexpired term of the vacated office and shall be made in the same manner as original appointments.

30-11-706. Organization of commission. The commission shall elect from its membership a chairman, a vice-chairman, and such other officers as it deems necessary. The vice-chairman shall act as chairman in the absence or disability of the chairman. The commission shall meet on call of the chairman but not less than once every month. A majority of the members of the commission shall constitute a quorum for the transaction of business.

30-11-707. Compensation - expenses. The members of the commission shall not receive compensation for their services, but they shall be reimbursed for expenses incurred by them in the performance of their official duties.

30-11-708. Duties of commission. (1) The commission shall:

(a) Review all applications for nursing home placement and determine eligibility for alternative care, such determinations to be based on guidelines provided by rules and regulations promulgated by the department;

(b) Advise the board of county commissioners on all aspects of home care services, advise in the review and coordination of efforts among agencies to develop home care services, and make appropriate recommendations to the board of county commissioners concerning home care services;

(c) Prepare plans for the delivery of home care services and submit such plans to the board of county commissioners;

(d) Within one year of the effective date of the part 7, and annually thereafter, provide the board of county commissioners and the general assembly with a report on the availability and quality of home care services in the state and the costs associated therewith. Such report may include recommendations for appropriate state and federal legislation, rule and regulations, and other actions which would enhance the availability, appropriate utilization, and coordination of home care services in this state.

(e) Seek and utilize any available federal, state, or private funds which will be available for carrying out the purposes of this part 7, including but not limited to medicaid funds, pursuant to title XIX of the federal social security act;

(f) By a majority vote of its members, adopt and amend rules and regulations, subject to the approval of the board of county commissioners, to effectuate the provisions and purposes of this part 7 with respect to certified home health agencies and providers of long-term home health care programs, including, but not limited to:

(I) The establishment of requirements for a uniform statewide system of reports and audits relating to the quality of services provided and their utilization and costs;

(II) Establishment of schedules of rates, payments, reimbursements, grants, and other charges;

(III) Standards and procedures relating to certificates of approval and authorization to provide long-term home health care programs;

(IV) Uniform standards for quality of care and services to be provided by certified home health agencies and providers of long-term home health care programs;

(V) Requirements for minimum levels of staffing, taking into consideration the size of the agency or provider of a long-term home health care program, the type of care and service provided, and the special needs of the older persons served;

(VI) Standards and procedures relating to contractual

arrangements between home care services agencies;

(VII) Requirements for uniform review of the appropriate utilization of services; and

(VIII) Requirements for minimum qualifications and standards of training for personnel as appropriate.

30-11-709. Certification of home care services agencies. The department of health shall issue a certificate of approval to any public or voluntary nonprofit home care services agency qualified to participate as a home health agency under title XVIII of the federal social security act applying therefor which complies with the provisions of this part 7 and the rules and regulations promulgated pursuant thereto. No such public or voluntary nonprofit home care services agency shall be operated unless it possesses such valid certificate of approval.

30-11-710. Appropriations. (1) For carrying out the duties and obligations of the counties for the administration and provision of services to those determined eligible under section 30-11-708, all medicaid funds, pursuant to title XIX of the federal social security act, appropriated for nursing home care shall be divided by the department among the several counties of the state on a per capita basis, such funds to be utilized by the counties for nursing homes or alternatives to nursing homes as each county shall determine.

(2) All funds received must cover administrative as well as program costs, and administrative costs shall not exceed ten percent of the total amount appropriated under this section.

30-11-711. Gifts - grants. The department, acting for and on behalf of the state, may receive and accept title to any grant or gift from any source, including the federal government, and all grants, grants-in-aid and gifts shall be deposited with the state treasurer and shall be continuously available to the department to carry out the purposes of this part 7.

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.

COMMITTEE ON HEALTH, ENVIRONMENT,
WELFARE, AND INSTITUTIONS

BILL 54

JOINT RESOLUTION NO.

WHEREAS, The interim committee on health, education, welfare, and institutions was charged with the task of studying senior citizens in Colorado and their needs and existing federal, state, and local programs which provide services to senior citizens and of developing a coordinated and comprehensive state policy on senior citizens; and

WHEREAS, The committee has met regularly during the interim period and has taken testimony and evidence from a wide variety of public and private agencies, concerned citizens, and other sources which are active in the field of aging; and

WHEREAS, It appears that the current system is not as effective and successful as it could and should be and that consequently there is a great need for a change in the current system of meeting the needs of senior citizens; and

WHEREAS, The task which the committee undertook was so awesome that time has not allowed a comprehensive and adequate solution to be worked out; now, therefore,

Be It Resolved by the of the Fifty-second General Assembly of the State of Colorado, the concurring herein:

(1) That a committee, to be known as the joint review committee on aging, should be established to examine and review the findings of the 1978 interim committee on health, education, welfare, and institutions and to develop recommendations to the general assembly for an administrative structure for administering, coordinating, developing, and overseeing Colorado's aging programs. It shall further be the duty and responsibility of the joint committee to review the role of the Colorado commission on aging relative to Colorado's aging program, as that role is provided for in section 26-11-105, Colorado Revised Statutes 1973, and to report its findings and recommendations to the senate and house committees on health, education, welfare, and institutions on or before March 15, 1979.

(2) (a) That the membership of the joint review committee on aging shall consist of eleven members, appointed as follows: The speaker of the house of representatives shall appoint two representatives from the majority party and three private citizens from the community-at-large who are representatives of agencies providing direct service to senior citizens; the minority leader of the house of representatives shall appoint one representative from the minority party; the president of the senate shall appoint two senators from the majority party and two private citizens from the community-at-large who are consumers of services provided under Colorado's aging program; and the minority leader of the senate shall appoint one senator from the minority party. Members shall not be compensated for services rendered on the committee.

(b) The staff of the legislative council shall serve as staff for and assist the joint review committee in the performance of its responsibilities, duties, and functions.

(3) Appointments to the committee shall be made and the work of the committee shall commence as soon as practicable after the adoption of this resolution.

COMMITTEE ON HEALTH, ENVIRONMENT,
WELFARE, AND INSTITUTIONS

BILL 55

JOINT RESOLUTION NO.

WHEREAS, The State of Colorado has received since 1975 federal funds under the "Older Americans Act of 1965" for the establishment and maintenance of a nursing home ombudsman program to advocate the rights of nursing home residents, to educate such residents and the general public as to relevant problems and solutions, to investigate and resolve complaints of such residents, and to provide other services relative to the rights, welfare, health, and safety of such residents; and

WHEREAS, For the past three years, this program has been contracted out by the Division of Services for the Aging of the Colorado Department of Social Services with the result that the program has been run with effectiveness, efficiency, competence, and success; and

WHEREAS, The Colorado State Board of Social Services has recently approved the termination of the past policy of contracting out for the services of an ombudsman and the consolidation of this program and the Division's legal services developer into one program under and within the Division; and

WHEREAS, The continuation of the past policy of contracting out with an independent provider would eliminate the strong potential for a conflict of interest which would exist if the consolidation occurred and which would probably weaken the ombudsman's effectiveness, and such continuation would insure full political freedom necessary for the effective functioning of the ombudsman; and

WHEREAS, There has been much opposition to the consolidation from senior citizen organizations and other groups throughout Colorado which provide services to the aged; and

WHEREAS, It is vitally important that the ombudsman be as effective, aggressive, and responsive as possible to the rights, complaints, needs, conditions, safety, health, and welfare of nursing home residents; now, therefore,

Be It Resolved by the of the Fifty-second General Assembly of the State of Colorado, the concurring herein:

(1) That it is the feeling and sentiment of the General Assembly of the State of Colorado that the nursing home ombudsman program remain independent of any and all state departments and agencies, that, in particular, the ombudsman program not be brought under and into the Division of Services for the Aging of the Colorado Department of Social Services, and that, to insure independence, the Division of Services for the Aging contract out for the provision of services under the ombudsman program to such entity as is determined by the Colorado Commission on the Aging.

(2) That the Administration on Aging of the United States Department of Health, Education, and Welfare allow the Colorado Department of Social Services to continue to contract out for the provision of services under the nursing home ombudsman program and permit the continued separation of the ombudsman and the legal services developer.

Be It Further Resolved, That copies of this Resolution be sent to the Executive Director of the Colorado Department of Social Services, the Chairman of the Colorado Commission on the Aging, the Chairman of the Colorado State Board of Social Services, the Governor of the State of Colorado, and the Commissioner of the Administration on Aging of the United States Department of Health, Education, and Welfare.