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0256 Committee on Health, Environment, Welfare, and Institutions

Colorado Legislative Council

0256 Committee on Health, Environment, Welfare, and Institutions

Report to the Colorado General Assembly:

RECOMMENDATIONS FOR 1981 COMMITTEE ON:

HEALTH, ENVIRONMENT, WELFARE, AND INSTITUTIONS

COLORADO LEGISLATIVE COUNCIL

LEGISLATIVE COUNCIL

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 onstaffing standing committees, and, upon individual request, supplying legislators with personal memoranda which provides 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 1981

(Colorado. Legislative Council.

COMMITTEE ON HEALTH, ENVIRONMENT,

WELFARE, AND INSTITUTIONS.)

Legislative Council

Report to the

Colorado General Assembly

Research Publication No. 256
December, 1980

COLORADO GENERAL ASSEMBLY

LEGISLATIVE COUNCIL

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DENVER, COLORADO 80203
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To Members of the Fifty-third Colorado General Assembly:

Submitted herewith is the final report of the Legislative Council Committee on Health, Environment, Welfare, and Institutions for 1980. The report of the Health, Environment, Welfare, and Institutions Committee is one of a series of nine volumes containing the reports of all of the Legislative Council committees (Research Publications Numbers 249 through 257).

Respectfully submitted,

/s/ Senator Fred Anderson
Chairman
Colorado Legislative Council

FA/th

FOREWORD

Four topics were assigned to the 1980 interim Committee on Health, Environment, Welfare, and Institutions. Three topics were assigned to the committee by Senate Joint Resolution No. 26 of the 1980 session of the General Assembly -- a study of mental health programs in Colorado, a study of rural health programs, and a study of the Medicaid Management Information System. Additionally, the Legislative Council authorized the committee to conduct a study of Colorado's statutory provisions for life care institutions.

The Legislative Council reviewed this report and recommendations at its meeting on November 24, 1980, and transmits the report and the one bill included herein with favorable recommendation to the 1981 session of the General Assembly.

The committee and the staff of the Legislative Council were assisted by Marcia Baird of the Legislative Drafting Office in the preparation of the bill contained in this report.

December, 1980

Lyle C. Kyle
Director

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INTRODUCTION

Through provisions of Senate Joint Resolution No. 26, the Legislative Council directed the interim Committee on Health, Environment, Welfare, and Institutions to conduct a study of the following topics:

-- A study to identify the needs of the state mental institutions, community mental health centers, including capacity and funding considerations, and the problems of the chronically mentally ill living in alternative housing, and to assure effective care of the mentally ill with a view towards protecting the public from dangerous mentally ill persons while preserving the rights of mentally ill persons.

-- A study of rural health programs available within this state with a view towards identifying the various programs and coordinating the programs to avoid duplication and make better use of state and federal funds.

-- A study of the Medicaid Management Information System.

In addition, the Legislative Council assigned a fourth topic to the committee.

-- A study of life care institutions with the objective of reviewing and recommending changes in the statutory provisions for these institutions.

MENTAL HEALTH PROGRAMS

The study of mental health programs consisted of an examination of various aspects of mental health services provided by state institutions and by the community mental health centers throughout the state. Included in this study was a review of mental health funding and consideration of issues concerning the treatment of, and facilities for, the chronically mentally ill and the dangerous mentally ill.

Numerous persons familiar with mental health services were heard -- representatives of institutional and community programs, psychiatrists and psychologists, professional associations, a district court judge, families of mental health patients, and patients themselves. The committee also toured some community mental health centers and state residential facilities.

Since the interim Committee on Judiciary studied issues relating to the criminal defense of insanity and civil commitments of the mentally ill, reference should be made to the final report of that committee.

Violent Acts Committed by Mental Health Patients

In 1979, Colorado experienced several episodes of violent acts committed by former mental patients or by patients who had been released from state mental institutions for treatment in the community. In April, 1980, the Governor directed that the Department of Institutions, through its Division of Mental Health, undertake a thorough examination of the policies and procedures for the assessment, treatment, and discharge of the violent mentally ill. The preliminary results of that investigation were published in June in a report entitled Violence and the Mentally Ill. The objectives of that report were to assess the scope of the situation in Colorado; to identify specific problem areas; to recommend immediate steps to be taken; to identify areas needing more extended evaluation; and to develop a process for future solutions.

Representatives of the Department of Institutions reported on the findings contained in the report and the immediate steps being taken by the Division of Mental Health to address needed procedural changes. In a subsequent meeting, the division stated that, as a result of the report and the responses to it, the following actions were being taken:

-- The Department of Institutions, in order to increase control over the potential release of violent patients, has elevated certain responsibilities to a higher administrative level. The department is implementing changes concerning patient identification; review of transfers, terminations of certification, and releases; and discharge boards.

-- In some cases, the department has begun a process of obtaining, within constitutional limits, the criminal records of known or suspected violent mental patients. A letter has been sent to the Attorney General asking for advice about the acquisition of criminal records.

-- The Governor's Task Force on Insanity has been instructed to consider determinate commitment related to the degree of harm caused by the crime under consideration and revision of the incompetent to stand trial provisions consistent with Jackson v. Indiana.

-- The department is conducting a study of emergency practices in handling violent patients. Centers and clinics throughout the state are being studied and the department is developing statewide guidelines.

-- The department is conducting an analysis of security practices in the state hospitals.

-- The department is continuing to evaluate and develop recommendations on the following issues:

  * coordination of the mental health, judicial, law enforcement, and health systems;

  * the public policy for civil commitment of dangerous persons; and

  * training programs for staff in the care of the violent patient.

-- The administration is reviewing what budget requests, if any, would be appropriate and necessary to carry out any of these recommendations.

Community Mental Health Treatment

Congress enacted the "Community Mental Health Centers Act" in 1963 to provide funds for the construction and staffing of community-based treatment programs for mental patients. This legislation was enacted in response to the growing belief that the needs of the mentally ill could not be best served by continuing the practice of "warehousing" patients in large, over-crowded, and usually under-staffed state hospitals. The objective of community-based treatment was to remove patients from hospital beds and provide treatment in a setting closer to their own homes.

The act and its subsequent amendments provided that community mental health services would be furnished by independent centers serving specific geographic areas. Regulations under the act mandated that, if organizations in a state were to be eligible for the new federal funds, the state must formulate a plan which divided the state into catchment areas with populations of between 75,000 and 200,000 people. Each catchment area can be served by a single community mental health center, the establishment of which could be sponsored by either a public or a private organization.

Catchment areas in the city and county of Denver. When Colorado's state mental health plan was approved, Denver was divided into four separate catchment areas, and a separate community mental health center was established in each. The four centers, each governed by its own board of directors are: Southwest Denver Mental Health Center; Bethesda Mental Health Center; Park East Mental Health Center; and the Denver Health and Hospitals Mental Health Program. These four autonomous centers in Denver (three with independent boards of directors and one operated by the City and County of Denver), have experienced conflicts in administration and in providing service to the mentally ill.

An example cited concerning the lack of coordination between the centers is in the provision of emergency mental health services.

Denver General Hospital, perhaps the most visible emergency treatment facility in the metropolitan area, frequently is used by persons needing emergency mental health services. Although each mental health center is responsible for providing mental health services (including emergency services) to the residents of its catchment area, Denver officials state that they have been placed in the position of providing emergency services to residents of all the Denver catchment areas. Because Denver General Hospital is a part of the Denver Department of Health and Hospitals, their mental health program has been required to provide services for which other centers are responsible.

Between 1974 and 1977, efforts were undertaken to develop a coordinated working relationship between the four community mental health centers in Denver. Attention to increasing coordination was initiated through a provision in the 1974 long appropriations bill, but ultimately was unsuccessful and no further efforts to resolve these conflicts have been undertaken since that time.

Funding of community mental health centers. The current formula for state funding of community mental health services calculates funds available to a center relative to the total population of the catchment area. According to the Division of Mental Health, there exists a wide disparity of per capita funding levels among catchment areas, with variations of up to 500 percent. New state dollars are being allocated to the lowest per capita funded centers to rectify these discrepancies and to bring them closer to the per capita funding level of other centers.

A new method has been proposed by the division for distributing funds on a "need" formula. Several "need" indicators (including suicide rates, unemployment, and minority population, among other factors) are used to modify the catchment area's population to indicate the population "in need". Distribution of new funds would then be based on relative need in the catchment area rather than using straight-line population figures.

The use of a relative need model is supported by those centers having high populations in need, such as the Capitol Hill area of Denver, where significant numbers of deinstitutionalized mental patients reside. Representatives of other catchment areas maintain that to use such a formula would perpetuate the inequities currently experienced by the lowest per capita funded centers. Also, it was stated that equal proportions of severely and moderately disturbed clients are being treated by all community mental health centers in the state, obviating the need to change to a "need-based" system.

Decreasing number of community residential facilities. Many patients released from state institutions for community mental health treatment have relied on boarding homes and some nursing homes for residences. For those former patients who are not able to function independently, but who do not require twenty-four hour supervised care, boarding homes, in particular, appear to have provided the level of care needed.

Boarding homes themselves are not eligible for direct Medicaid institutional reimbursement, but a majority of their residents may subsist on Medicaid allowances, often the only source of income to the resident. As with other Medicaid reimbursements, these allowances have become increasingly inadequate in the face of rising costs experienced by the boarding home operators, especially if even a minimal level of supervision and care is to be provided. Thus in recent years, there has been a steady decrease in the number of boarding homes, which typically have been operated as private enterprises, and there is increasing pressure on public resources to provide alternative housing for formerly institutionalized persons. There has been an increase in the number of patients who move into independent living situations where no opportunity exists for any degree of supervision, such as in the taking of medication.

The availability of nursing home facilities has declined markedly as the result of regulations by the Department of Health which prohibit a nursing home from having more than fifty percent of its clientele as psychiatric patients. Further, use of nursing homes to house deinstitutionalized mental health patients has met with a mixed reaction. To some observers, the use of nursing homes with adequate, skilled staff is an acceptable method of providing care to psychiatric patients needing a level of supervision that falls between intense in-patient care and minimally supervised community-based care. An opposite view is that nursing homes can become the "dumping ground" for patients who should more appropriately be served by institutional facilities within the community. They also maintain that having former mental patients in this setting is detrimental to the other patients at the nursing home.

Need for additional community treatment services. A number of services were mentioned as being necessary to provide a continuum of care for patients needing community-based treatment. These services include 24-hour psychiatric emergency services, availability of other out-patient services, and an increasing number of programs for patients who are progressing from institutional to community-based treatment.

Institutional Mental Health Services

The trend toward deinstitutionalization for the care and treatment of the mentally ill became a standard practice nationwide in the decade of the 1960's. A number of factors can be cited which provided the impetus for deinstitutionalization, perhaps most significant of which was the previously mentioned Community Mental Health Centers Act of 1963.

The impact of deinstitutionalization in Colorado can be seen in average daily attendance figures for the Colorado State Hospital (CHS) in Pueblo over several years:

Fiscal Year	CSH Average Daily Attendance
1959-60	5,851
1969-70	1,864
1974-75	936
1978-79	703

These figures indicate that the number of persons receiving institutional treatment has declined significantly during the last two decades. As deinstitutionalization occurred, the expenditure of public funds for hospital treatment declined relative to the amount spent for community treatment of mental patients. A representative of the Division of Mental Health reported that, in 1978, the amount of funds spent from all sources for community programs for the first time surpassed the total expenditure for institutional treatment in Colorado.

Shortage of institutional bed space. As the policy of deinstitutionalization has progressed and resources shifted toward community programs, fewer inpatient beds have been available for the care of persons in need of intensive institutional care. The committee was told that the demand for inpatient care now exceeds the supply of beds to the extent that waiting lists exist for the placement of patients at both the Colorado State Hospital and the Ft. Logan Mental Health Center. In the case of both facilities, the waiting period averages several months, and the problem is intensified by insufficient alternative placements and the increasing shortage of nursing home and boarding home beds.

Representatives of both community-based and institutional mental health programs recommended that more state-funded inpatient beds be provided to adequately treat patients who are experiencing intense, acute psychiatric disorders. The capability of community programs to provide care of this nature was said to be neither adequate nor appropriate.

Need for intermediate care facilities. Another recommendation presented concerned the need for twenty-four hour, intermediate care facilities. The existing structure of mental health programs has evolved so that appropriate services are available for patient needs on either end of the spectrum -- highly structured institutional treatment and minimally supervised community-based treatment -- but not for the patient needing an intermediate level of care.

The syndrome of the so-called "revolving door" is related primarily to the chronically mentally disabled. The experience of the mental health system with this group has been a cycle of: institutional care; release to a community mental health center; commission of an act that requires law enforcement or emergency services intervention; and recommitment to institutional care. These patients, whose conditions are non-reversible, are characterized as a group for which neither full-time institutionalized care nor unsupervised community living is appropriate. The lack of adequate institutional bed

space, however, has caused a dilemma over the placement of these individuals, and the need for alternative placements has resulted in the costly overuse of community hospital beds, emergency and diagnostic facilities, and sometimes the inappropriate use of county jails. Many persons indicated that the problem was most severe in the core city (Denver) where many of the chronically mentally ill have migrated for a variety of reasons.

Since the use of state inpatient facilities is intended for short-term treatment of the acutely mentally ill, it was recommended that the state establish a new type of residential treatment facility for intermediate level long-term care of the chronic patient, for whom the "revolving door" syndrome has become a way of life. These facilities would be accessible to persons from both institutional and community programs who are chronically mentally ill.

Committee Recommendations

The committee submits no specific recommendations at this time but recognizes the need for additional legislative consideration of several issues. The issues needing attention include: the concept of intermediate care facilities for the chronically mentally ill; possible remedies for the lack of coordination between the four community mental health centers in Denver; and the long-range implications of per capita funding for community mental health centers. Each possible approach for solving the problems cited in this report needs to be examined thoroughly, particularly before state funds are committed for new facilities or programs.

The committee urges continued legislative review of executive branch actions and recommendations concerning mental health. Recommendations from the Department of Institutions which concern the issues addressed in this report -- administrative problems, levels of funding, the need for more facilities or additional mental health beds -- should be carefully reviewed.

Finally, the 1981 standing committees on Health, Environment, Welfare, and Institutions should also coordinate their discussions on mental health issues with the activities of House and Senate Committees on the Judiciary to ensure that the legislative committees are acting with consistent objectives.

RURAL HEALTH

Senate Joint Resolution 26, 1980 session, directed a study of rural health programs to ascertain the need for coordination between programs, to determine the extent to which duplication of program services exists, and to obtain better application for state and federal funds. Hearings were held on these subjects at the Colorado Rural Health Conference at Keystone in October. Individuals and representa-

tives of organizations providing rural health services addressed the issues of coordination, duplication, and funding of rural health services.

In preparation for these discussions, the Legislative Council staff prepared an inventory of state-sponsored programs which have a primary focus on rural health service delivery and this inventory is appended to this report (see Appendix, pages 55-69). Further, the committee reviewed specific problem areas identified in a 1978 interim study at which time several new state-sponsored programs were being implemented. The objectives, services provided, and accomplishments of these relatively new programs were discussed at the Keystone conference.

Colorado Office of Rural Health

The Office of Rural Health was established in January, 1978, by Executive Order of the Governor, to serve as a central agency concerned solely with rural health matters. The establishment of the office was initially recommended in 1977 by the Governor's Commission on Rural Health Manpower Solutions, with the support of the University of Colorado Health Sciences Center and the Colorado Department of Health. In its first year, the Office of Rural Health was situated in the Office of the Governor; thereafter it has been in the Office of the Lieutenant Governor. The director of the office, Jack Locke, M.D., explained that one objective of the office is to ensure that rural health issues are addressed in the formulation and execution of state policy. Further, the office attempts to provide linkages for information and resources between urban and rural communities, between federal, state, and local units of government, and between the public and private sectors.

Activities of the office include publishing a newspaper concerning rural health; sponsorship of the Rural Health Manpower and Recruitment Consortium; conducting a special study to assess the chronic shortage of nurses in rural hospitals and nursing homes; and the promotion of volunteer health services in rural areas.

The committee was concerned that the office does not have, nor has it ever sought, legislative recognition for status as a state function. At the time of its establishment by executive order, legislation to create such an office was pending before the General Assembly, but was removed from consideration when the Governor acted to create the Office of Rural Health. Committee members were critical of the failure of the office to communicate with the General Assembly.

Manpower Programs for Rural Health

The most commonly cited deficiency in the delivery of rural health services in Colorado has been the lack of adequate health manpower in rural communities. The 1978 Committee on Local Government

stated that the lack of primary health care providers, or more correctly the maldistribution of providers, is the problem cited most frequently as the major cause of the lack of adequate rural health care in Colorado.

Several programs have been established to address the manpower needs -- the Colorado Rural Health Recruitment and Manpower Consortium, and three programs sponsored by the University of Colorado Health Sciences Center -- SEARCH (Statewide Education Activities for Rural Colorado's Health), M/POP (Mountain/Plains Outreach Program), and the Family Medicine Training Program. These programs are summarized in the inventory which accompanies this report.

Problems of Rural Health in Colorado

Persons meeting with the committee at Keystone offered the following responses to issues of duplication and coordination of program services, uses for state and federal funds, and priority needs in rural health.

1. Does there appear to be a duplication of effort between various programs?

Office of Rural Health: "We have counted at least sixty-five organizations that are active in rural health, and we have not seen any significant duplication among them. This lack of duplication has come as a surprise to us. It appears that rural health programs are developed because of a vacuum that exists in a specific area for a specific service."

Family practice physician, Glenwood Springs: "I see no serious instances of significant duplication, but what little exists -- in continuing education, family planning, visiting nurse programs -- is very small and involves little amounts of money."

2. How are services coordinated between programs, or is coordination a problem?

Manpower Consortium (The Rural Health Manpower and Recruitment Consortium, Office of Rural Health): "There is active coordination between the health manpower programs in the state. The consortium receives information from the medical society, whose computer lists openings for physicians around the state. The medical society program works well for urban areas but not for rural ones, so all rural inquiries are referred to the consortium. The Colorado Nurses Association refers all their rural inquiries to the consortium. Also, the community nursing component of the Department of Health places community public health nurses in rural areas, so all inquiries of this nature received by the consortium are referred to the department. The consortium also actively works with SEARCH, M/POP, the National Health Service Corps, the Rural Health Care Association, the Academy of

Physician Assistants, and others in a conscious attempt to coordinate efforts."

Director of an Area Health Education Center (AHEC) in the SEARCH program: "The role of the AHEC's around the state are to act as a vehicle for coordination of resources in their own region. An area for improved coordination, we have found, is continuing education programs sponsored by institutions, like rural hospitals. The AHEC could provide that service, and thus free up the time devoted to continuing education by institutional personnel."

Office of Rural Health: "We see our role as serving as a catalyst between rural needs and available resources. A large part of the problem in rural health is the inability to quickly transfer urban-developed medical technology to rural areas. Several new programs are addressing some aspects of this problem but there remains an inordinate lack of this transfer."

Family practice physician, Glenwood Springs: "Coordination of programs unquestionably does not occur as it should. One of the priority needs in rural health is the coordination of program services already available."

3. How can state and federal funds for rural health programs be used more effectively?

Office of Rural Health: "It is our opinion that Colorado is blessed with a lot of health resources, and that the problems being experienced are not money problems. Though funding, of course, is important, the infusion of more money won't solve rural health problems. A suggestion we would make is to allow the Office of Rural Health to play an expanded role in helping match our abundant resources to existing needs."

Family practice physician, Glenwood Springs: "It is virtually impossible to supply all the needs of rural health programs with the funds available. I would suggest that a reorientation of values is necessary rather than a continued reliance on public funds. We need to develop a more cost-effective health system which provides: economic incentives to patients, practitioners, and institutions which encourage the patient to assume responsibility for remaining well; we need to spend less money for exotic procedures and more money on basic human needs; and we must spend less money on end-of-life technology."

Rules, Regulations, and Statutes Affecting Rural Health

A task force of rural health professionals, organized at the 1979 rural health conference, presented the committee with a summary of issues concerning state statutory and regulatory policies adversely affecting rural health. These issues included: the impact on rural areas of the alternatives to nursing homes program established by Senate Bill 38 (1980 session); the effect of low Medicare and Medicaid

reimbursements on rural hospitals and health care providers; the impact of state-mandated programs with no appropriated funds; the need for birthing centers in rural areas; recommended salary increases for public health nurses; and the utilization of physician assistants and nurse practitioners in rural areas.

Committee Recommendations

Most of the recommendations of the rural health task force on rules, regulations, and state laws are addressed more appropriately in the state budgeting and appropriations process and will be issues in the 1981 session of the General Assembly. Other problems -- coordination of services, in particular -- involve administrative agencies and need to be examined in greater detail than time permitted during this interim period.

The committee recommends that representatives of the Office of Rural Health and the SEARCH, M/POP, and Family Practice programs at the University of Colorado Health Sciences Center, as well as representatives of other state programs for rural health, review with the two HEWI Committees in the 1981 session their current activities and approaches used in addressing the problems identified. Administrative issues can be considered in greater detail in the context of specific legislation under consideration.

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

The study of the state's Medicaid Management Information System was directed by the General Assembly in response to the large number of complaints received during the 1980 session concerning the Medicaid reimbursement system from providers of Medicaid services. Several hearings were held by the Senate Committee on Health, Environment, Welfare, and Institutions on this issue during the 1980 session and the information presented appeared to substantiate claims that numerous problems existed in the newly implemented reimbursement mechanism.

During the Senate hearings, a number of service providers, representing a wide range of Medicaid services such as medicine, laboratory services, transportation providers, and nursing homes, presented their complaints. The interim committee, however, directed its attention to the responses from Medicaid program administrators to the issues brought forth in the providers' earlier testimony.

This report will describe briefly the purposes for which the Medicaid Management Information System program was developed, its implementation in Colorado, the nature of the problems experienced by Medicaid service providers, and the responses and corrective actions of Medicaid program administrators to the reported deficiencies.

Background Report

The Medicaid Management Information System is a computerized program for the processing of reimbursement claims submitted by the providers of Medicaid services. The administration of the state's Medicaid program is the responsibility of the Department of Social Services, although the program is operated by Blue Cross/Blue Shield of Colorado acting as the state's Medicaid fiscal agent under contract with the Department of Social Services. The duties of the fiscal agent are to receive and process reimbursement claims for services rendered by providers, and to notify the department of actual reimbursement payments they are to make to providers. The fiscal agent function has been performed by Blue Cross/Blue Shield since the beginning of the Colorado Medicaid program in 1969, and it was also granted the contract to serve as fiscal agent under the new Medicaid management program.

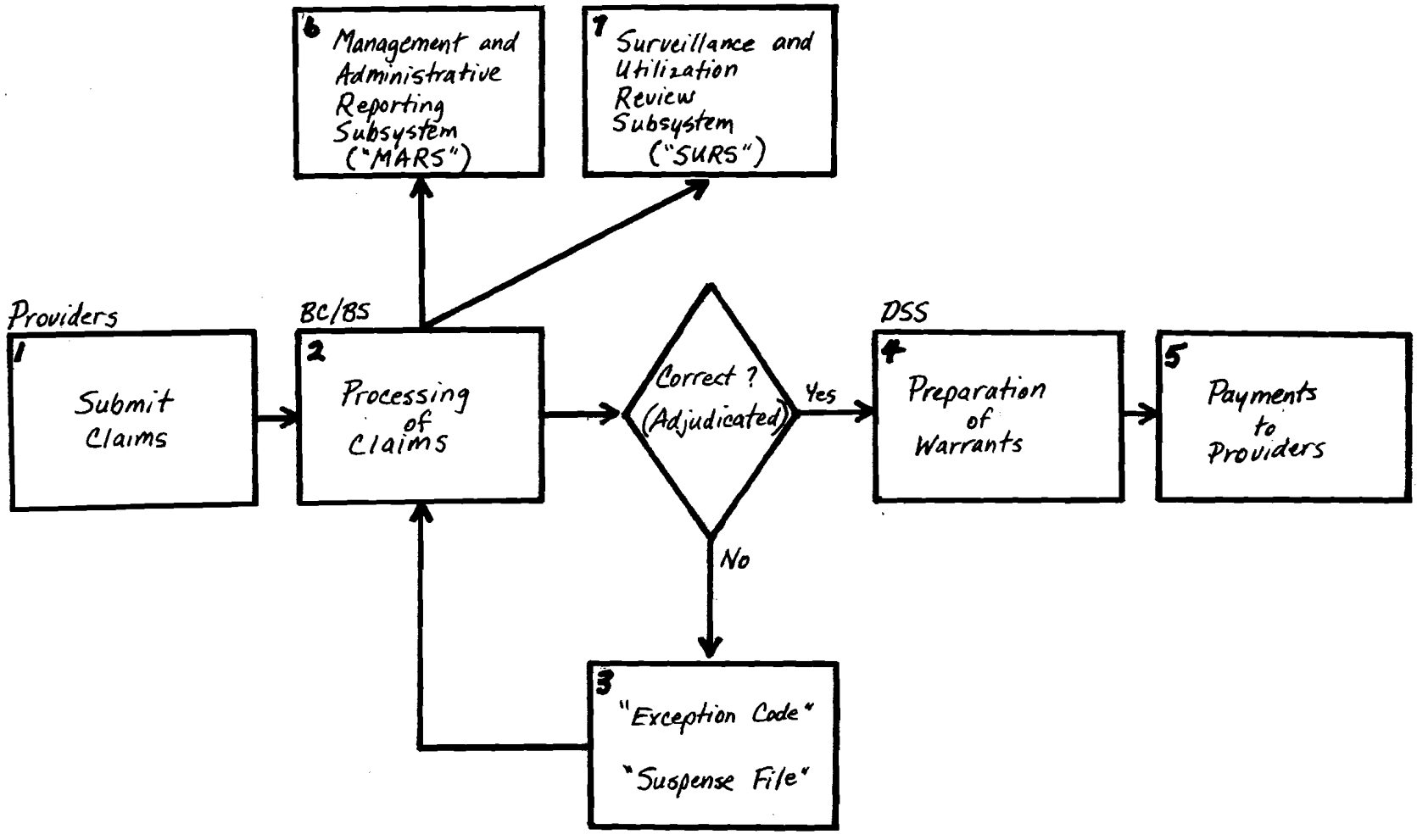
Federal initiatives. In 1972, federal legislation was passed to encourage states to develop data processing systems for the management of Medicaid programs. The objective of this legislation was to provide states with integrated computer processing operations to: process and pay bills for health care services given Medicaid recipients; store and retrieve service and payment data for use in monitoring and analyzing program activity; and, generate management reports. As incentives to the states for the development of such systems, the federal government would reimburse states for ninety percent of the cost of the initial development of systems which complied with federal specifications and thereafter, to reimburse them for seventy-five percent of the cost for the on-going operation of the certified system, instead of the usual fifty percent cost sharing for administration of Medicaid.

Development of The Medicaid Management Information System in Colorado. Between 1976 and 1978, the Department of Social Services received legislative authorization for a Medicaid management program and specifications were developed for a certifiable system. Early in 1979, Blue Cross/Blue Shield was selected as the fiscal agent for the new program and it was granted a two-year contract through June 30, 1981, with the option of two one-year extensions. The first groups of providers in the phased-in implementation process came on-line in June, 1979. By October, 1979, all Medicaid service providers' claims were being processed through the new Medicaid management system.

Overview of MMIS

The graphic on the following page displays the basic components of MMIS in a flowchart fashion.

MMIS Overview



The processes depicted in the graphic are:

1. After medical services are rendered by authorized providers, a claim for reimbursement is submitted on an approved form to Blue Cross/Blue Shield.

2. The system is programmed with information pertaining to eligible recipients, approved providers, and a "reference file", which stores data pertaining to the current rates of payment for various medical procedures and services. In the processing of claims, this information is used by the computer to "adjudicate" claims to determine whether claims are complete, accurate, and eligible for reimbursement.

3. If an error in the claim is discovered, it is rejected by the computer and an "exception code" is entered on the claim. The exception code requires that the claim be processed further. Sometimes, the error can be corrected by Blue Cross/Blue Shield, and the claim is reprocessed manually and adjudicated. If it cannot be corrected, the claim goes to the "suspense file", meaning that payment on the claim is withheld until the errors can be corrected, either by the fiscal agent or by the provider.

4. After adjudication, the information on the claim is forwarded to the department where warrants for payments and remittance statements to accompany the warrants are prepared.

5. Reimbursement warrants and remittance statements are sent to the provider.

6. "MARS", Management and Administrative Reporting Subsystem, compiles information from all claims processed to provide management information (mostly financial data) to keep track of overall program trends in the Medicaid program. The intent of the federal government in requiring this reporting subsystem was to facilitate sound decision-making by state legislatures and program administrators for Medicaid programs.

7. "SURS", Surveillance and Utilization Review Subsystem, also retrieves data from claims processed through the system for two basic purposes: to provide information that assesses the level and quality of care provided to Medicaid recipients; and to facilitate the investigation of suspected instances of fraud or abuse by Medicaid providers or recipients.

Reimbursement Problems Identified by Providers

Providers pointed out two separate types of deficiencies in the Medicaid management program -- problems in the prompt and accurate processing of provider's claims; and deficiencies in actual rates of reimbursement.

1) Claim processing problems. Representatives of several different provider groups cited the following as examples of problems in the processing of Medicaid claims:

-- Difficulties in preparing the forms under the new system. Providers are required to enter several specific code numbers on submitted claim forms to "program" the computer. This task was formerly completed by the fiscal agent, but is now required of the providers themselves. Preparing the forms is a difficult and time-consuming process as there are thousands of codes from which to select. Errors in coding often result in a delay in receiving payment or in the denial of the claim.

-- Problems in receiving payments. Providers explained the numerous difficulties they have had in reconciling the information between the remittance statement and in the payment they receive. Examples include: no patient names on statements; no reasons for denial of payments; erroneous denials; and different payment levels for the same procedure. Additionally, some payments have been sent to the wrong providers, and some claim forms have been lost. The effect of these problems is that providers have had to correct and resubmit their claims, further delaying payments already described as being untimely.

2) Low reimbursement rates. The major criticism of the Medicaid program cited by providers is the low reimbursement amounts for the services provided. One physician stated that the reimbursements he receives amount to a forty-five to seventy-five percent discount of his regular charges. Several providers stated that their reimbursement levels have not changed in over ten years. Providers stated that they are losing money by providing services to Medicaid patients and this loss forces them to increase their charges to private patients. Furthermore, the net effect of such low reimbursements is an increasing number of Medicaid providers who are discontinuing or severely curtailing participation in the program.

Responses by Program Administrators

The fact that a number of problems have been experienced during the implementation of the Medicaid Management Information System was acknowledged by the department and Blue Cross/Blue Shield. In explaining the operational problems it was stated at one meeting that: "As with any major systems conversion, there are bound to be operational problems discovered following the conversion. While the problems are not insurmountable, the resolution does require a prioritization of limited resources and a thorough understanding of what has to be fixed."

In devising a procedure for correcting errors in the new system, it was apparent that problems could not be identified until a complete changeover from the old system had occurred. Once the administrators were totally reliant on the new system specific problems

could begin to be identified (a procedure recommended by a consultant). As the processing of claims was begun, the day-to-day administrative problems became apparent and corrections to the program could then be made.

The following is a summary of the responses provided to the problem areas noted:

Responses to Operational Problems

1. Coding of claims by providers. A major contention among Medicaid providers has been the requirement that they utilize a new claim form which uses numeric codes instead of the former narrative. Specific problems cited included the difficulty in finding the appropriate codes from among the thousands available and the time required to complete the many questions on the form.

Program administrators explained that the decision to use forms that are "pre-coded", meaning that the provider need only to circle a procedure code number rather than write in the procedure, was made to speed the processing of claims and to assure that each payment is made for the procedure actually provided. Additionally, because some providers were skeptical of the payment rates chosen when coding was done by the fiscal agent, it was decided that providers should do the coding themselves. Federal regulations mandate 117 data elements on each claim form submitted, which results in the large number of questions that must be completed. Much of that information is not required for the processing of claims, but for preparing the MARS (Management and Administrative Reporting Subsystem) and SURS (Surveillance and Utilization Review Sybsystem) information and reporting elements of MMIS.

In response to the coding problem, new procedures and claim forms are being incorporated in the program. Providers are now allowed to submit alternate claim forms other than the standard Medicaid form. Specifically noted as an example is the Blue Shield "all purpose" form, which about 15,000 physicians are already utilizing. Other forms can be accepted if it can be demonstrated that they are widely used and can meet Medicaid data requirements.

2. Responses concerning the actual payment process. As previously noted, other difficulties cited by providers in the actual payment process included problems in the receipt of prompt and accurate reimbursements, rejected claims, lack of information on remittance statements, and reimbursements sent to the wrong provider.

Representatives of the department and Blue Cross/Blue Shield stated many of the problems previously cited have now been corrected. To demonstrate this progress fiscal agent representatives provided the committee with performance statistics reports thereon. (See the following table.)

MMIS Performance Statistics
For All Medicaid Services

	January 1980	April 1980	August 1980
CLAIMS PROCESSED IN MONTH	238,131	290,168	236,681
CLAIMS APPROVED FOR PAYMENT	205,779	243,534	206,946
CLAIMS DENIED	21,100	21,549	18,680
PERCENT APPROVED WITHOUT SUSPENSION	82.0%	81.9%	77.2%
CLAIMS IN PROCESS AT MONTH END	13,077	25,879	11,193
AS PERCENT OF PROCESSED AT MONTH END	5.5%	9.4%	5.0%
AVG. DAYS FROM SERVICE TO RECEIPT 1/	34.1	32.7	35.3
AVG. DAYS FROM RECEIPT TO ADJUDICATION 2/	9.8	7.4	6.5
AVG. DAYS FROM ADJUDICATION TO PAYMENT 3/	5.1	4.2	6.3
AFV. NUMBER OF ERRORS PER CLAIM	.8	*	*
PERCENT OF CLAIMS ADJUDICATED IN:			
10 DAYS	82.6%	87.5%	91.4%
20 DAYS	93.2%	98.3%	97.4%
30 DAYS	96.3%	99.1%	99.4%
45 DAYS	98.0%	99.4%	99.7%
60 DAYS	98.9%	99.6%	99.8%
INVENTORY -- MONTH END:			
PRE-MACHINE	30,249	16,500	10,142
AVG. DAILY PRODUCTION	8,400	7,840	7,859
DAYS WORK ON HAND	3.60	2.1	1.3

1/ Time from rendering of service by provider to receipt of reimbursement.

2/ Time from arrival of claims at BC/BS to completion of process and approval for payment.

3/ Time from approval at BC/BS to preparation and mailing of warrants and remittance statements by Department of Social Services.

* not reported

When compared over a period of time, program statistics indicate that the Medicaid management system is now processing claims at an overall level that administrators maintain is fairly near the system's optimum capability. There are some obvious areas for which improvement is still needed, however. Specifically cited as an improvement is the decline in the number of claims still in process at month's end from 25,879 in April to 11,193 in August, down from the previous 9.4 percent of the claims to 5.0 percent. The number of claims adjudicated in ten days rose to 91.4 percent in August (up from the April figure of 87.5 percent); and the pre-machine inventory at month's end (claims on-hand but not processed) was 10,142 in August (down from the April inventory of 16,500). In any case, there are a certain number of claims that need to be suspended due to questionable or unusual services (these will need manual intervention), and the optimum number of claims processed without suspension is projected to be between seventy-five to eighty percent.

Responses to the Issue of Reimbursement Levels

Representatives of the Department of Social Services agreed with providers that low reimbursement rates are the major deficiency in the Medicaid program. Until the 1979-80 fiscal year, physicians had not experienced an increase in rates since 1974 and reimbursements for transportation services have not increased since 1969 (the year of the origination of the Colorado Medicaid program).

The possible curtailment of Medicaid services by providers due largely to the low reimbursement rates was a major factor for the department's initiation of discussions with representatives of various provider groups on intended changes in rate structures. It should be pointed out that the loss of primary care medical services (family practice, general practice, pediatrics, and obstetrics/gynecology) in a physician's office has the effect of forcing Medicaid patients to seek services in hospital emergency rooms, which averages about triple the cost of an office visit. The department representatives emphasized that this underscores the necessity of assuring that Medicaid reimbursement rates are at an adequate level.

Other Elements of the MMIS System

The Management and Reporting Subsystem (MARS) is now capable of producing Medicaid data for an entire year, and can produce financial reports consistent with Medicaid line-items in the long appropriations bill. These data are far superior in terms of both completeness and detail to any available in the past. This kind of reporting was one of the priority objectives in developing the Medicaid Management Information System, and its value will be especially important in the budgeting for Medicaid services.

The Surveillance and Utilization Review Subsystem (SURS) will assist in the identification of fraudulent or abusive activities in

the Medicaid program. Reports currently being produced contain erroneous information but corrective action is underway. This is not fully in operation because the department initially gave a higher priority to claims processing and management reporting functions.

Committee Recommendations

The committee agrees that the development of the Medicaid Management Information System, and the efforts of program administrators to rectify problems reported by health care providers, is progressing in a satisfactory manner. No formal recommendations are being submitted, but the committee has asked the program administrators to continue reporting to the House and Senate Committees on Health, Environment, Welfare, and Institutions during the 1981 legislative session.

LIFE CARE INSTITUTIONS

On June 23, the Legislative Council directed the Health, Environment, Welfare, and Institutions Committee to conduct a study of the Cheyenne Mountain Highlands Life Care Center (commonly called "Highlands"), an institution located in Colorado Springs that was experiencing serious financial difficulties and possible foreclosure. Additionally, the committee was to examine the responsibility of the Board of Examiners of Life Care Institutions for the situation that had developed at Highlands.

In the provision of life care services, an individual makes an initial lump-sum payment (usually called an "endowment"), for lifetime living accommodations in a multi-unit facility. In addition, meals, health care, or other services may be provided by agreement between the resident and the operator. A monthly service fee is charged to each resident to cover certain operating expenses for these additional services. The endowment entitles the resident to a lifetime occupancy privilege, but the endowment is not a purchase of the unit. The ownership of the unit remains with the life care organization.

In its hearings, the committee was presented with a large quantity of information concerning: the history of Highlands' business transactions; concerns expressed about prospective purchasers of Highlands; results of audits and investigations into the financial status of the institution; and investigation of its owners, and its prospective buyers. After having been presented with this testimony, the committee decided to concentrate on possible deficiencies in the current statute which allowed a situation to occur that jeopardized the welfare of residents of a state regulated facility. The committee determined that it would be inappropriate for it to make any recommendation concerning the actual business transactions between private parties, particularly since the institution's problems were still at issue before the state regulatory board and appeared to be subject to possible litigation.

Legislation in Colorado concerning the regulation of life care institutions was first enacted by the General Assembly in 1973 when the Board of Examiners of Institutions for Aged Persons was created. Even though there were few such institutions in the state in 1973, the General Assembly concluded that some state supervision was required for this relatively new industry. In 1977, during a regularly scheduled Sunset review the Interim Committee on Health, Environment, Welfare and Institutions proposed a bill which was subsequently adopted in 1978 amending the act. The amendatory act changed the name of the regulating body to the Board of Examiners of Life Care Institutions in the Department of Regulatory Agencies; extended the board until its next Sunset review in 1983; and amended and expanded other provisions for life care.

Statutory Deficiencies

Following is a discussion of those statutory provisions which were identified by some in committee hearings as being deficient.

Inadequate reserve requirements. The act requires that a life care institution must have financial reserves equivalent to sixty-five percent of all endowments received, to ensure the operator's performance of contractual obligations. By statutory formula, the amount held in reserve on each contract can decrease over a period of time, but under a provision that was added in 1978, at no time shall there be less than thirty percent of the original reserve requirement maintained. An additional provision states that at least ten percent of the reserve must consist of cash deposits or securities. The other ninety percent of reserves can be held in real estate, furniture and equipment, or other investments.

A Department of Regulatory Agencies' representative suggested that present reserve requirements are inadequate. Under existing statutory provisions, Highlands can be at least $1.2 million in debt (according to an audit performed by the Division of Insurance), yet they could be in total compliance with the statutory reserve requirement with only $86,000 in a cash account (the amount equal to the ten percent cash reserve requirement). While Highlands was said to be out of compliance with the cash reserve requirement, the ten percent cash reserves demonstrates that a facility can be in compliance with the law but also be insolvent at the same time.

An additional aspect of the deficiency in the financial reserve requirement is that ninety percent of the reserves can be in the building itself. By just owning the building, an operator of a life care institution has met a large portion of the reserve requirement, but such reserves become liquid assets only after the sale of the building.

Inability to file lien on behalf of residents. The statute provides that valid life care contracts constitute a preferred claim against the operator's assets in the event of liquidation. When

necessary to secure the performance of life care obligations, the board is empowered to file a notice of lien against those assets on behalf of the residents.

Once the financial condition at the Highlands became known to the board, the first option available would be to move quickly to file a lien on behalf of the residents. However, in exploring that option, the Department of Regulatory Agencies was informed by the Attorney General's Office that the action of filing a notice of lien was not actually available to the state. A separate provision requires that each operator have a blanket fidelity bond, running in his favor, to to protect the operator from acts and omissions of his own employees. It was the opinion of the Attorney General that, once such a bond was acquired (as had been done by the operator of the Highlands) the state loses the right to file a lien against the operator's assets.

Inability of board to take action short of revoking license. In view of the apparent deficiencies at the Highlands, it was the opinion of the Department of Regulatory Agencies that the board had grounds for taking some formal action against the facility. The only real remedy left to the board, however, was to revoke its license, an option that the board did not wish to exercise as it would result in closing the facility. The residents would then be left without a place to live. The board determined that, since there remained some chance of the facility continuing to operate under a new owner who could honor existing contracts, revocation of the certificate would be inappropriate. It was suggested that a better alternative might be to authorize the board to appoint a receiver for a facility facing default on its obligations.

Lack of expertise for regulating life care institutions. The five-member Board of Examiners of Life Care Institutions is comprised of two members representing the industry and three members representing the public. The board's major source of expert assistance appears to be the Division of Insurance. Present law includes three separate references under which the board may request assistance from the division: for actuarial and economic studies of life care institutions; for evaluating any standard life care agreements filed with the board; and to aid in the determination as to whether or not sufficient financial reserves are established and maintained by any life care institution.

In the case of the Highlands, the board requested that the division conduct an audit of that facility and the board relied on the division's report to substantiate its financial problems, particularly with regards to the lack of maintenance of appropriate reserves.

The board's need for more expertise on a continuing basis was further illustrated by the handling of the annual audit reports filed with them in the past. A certified audit must be filed annually with the board and, under its own rules, the board requires such audits as a condition for renewal of certification. Although the board has received regular audits from the Highlands, the audits were not thor-

oughly reviewed so that the board could recognize any continuing financial difficulties occurring at that facility.

Because of the board's lack of expertise and assistance in financial and other matters, and because of the duties already performed on behalf of the board by the Division of Insurance, the Department of Regulatory Agencies recommended transfer of the board's functions to the Division of Insurance and that the board be abolished.

Cash funding. One of the problems which has hindered the board, and also resulted in increased costs for residents of life care institutions, is the cash funding for the operations of the life care board. There presently are six life care institutions in Colorado and, as is the case of the boards regulating other businesses, these institutions are assessed fees that are used for the payment of the expense of regulation. Given the extraordinary expenses of this board, and the relatively few institutions, fees assessed for board expenses have increased rapidly. These expenses, of course, are passed along to the residents.

Committee Recommendations

The committee recommends a bill which would repeal and reenact the present statutes concerning life care institutions. The bill, drafted in cooperation with The Department of Regulatory Agencies and the Division of Insurance, is intended to address the deficiencies cited in the present act. Below is a brief description of the bill's major provisions, and some reasons therefor.

Transfer of current functions to the Commissioner of Insurance. As proposed, the bill will abolish the Board of Examiners of Life Care Institutions and transfer the board's functions to the Commissioner of Insurance. The existing Insurance Board will assist the Commissioner of Insurance in the administration of his new duties. The rationale for this suggested change is based on several factors:

-- The Division of Insurance is authorized by statute to assist the Life Care Board in several of its functions. For example, the division provides actuarial and economic studies of life care institutions; it evaluates life care agreements; and it determines the sufficiency of reserves established and maintained by institutions.

-- Many aspects of the life care industry bear similarities to the insurance industry, making the commissioner the appropriate authority to regulate the life care industry. Furthermore, the division has the expertise and the staff capability of adequately providing for such regulation.

-- Several provisions of the proposed bill, especially those concerning the rehabilitation of an insolvent provider, are statu-

tory duties currently exercised by the commissioner.

-- The regulation of life care in the Division of Registrations is now paid for through cash funding which means that the activities of this board must be fully funded from the fees for licenses in the industry. Fees for a license for a life care institution are $9,507, and $2,377 is charged for the annual renewal to meet the board's expenses. Instead of continuing the cash funding requirement, the bill provides for funding of the regulatory activity from the state's general fund.

Rehabilitation of the provider's financial condition. As noted earlier, the committee found that the only real option available to the board in a situation similar to Highlands was to revoke the license of the institution. This option would likely force the closure of the facility, and could result in the discontinuation of life care services to residents. For this reason, a provision to allow the Commissioner of Insurance to place the facility under an interim receivership is recommended, which is equivalent to the commissioner's existing remedial authority over insurance companies that have become delinquent. Under the proposed bill, the commissioner could take this action if a life care institution has not met the reserve requirements, is insolvent, is in danger of becoming insolvent, or is financially unsound to the extent that it cannot perform its life care obligations to residents. The commissioner could assume direct supervision of the facility and continue its supervision until the deficiencies are rectified.

In lieu of these remedies, however, the bill also provides that the commissioner could apply to the district court for authority to assume management and possession of the facility for the purpose of financial rehabilitation. The proposed bill also sets forth the duties of the commissioner in the case of a court-ordered management and possession action.

Recording of lien against operator's assets. Under the current act, existing contracts are deemed a preferred claim against all operators' assets in the event of a liquidation. The proposed bill requires that a lien be filed by the Commissioner of Insurance on the operator's land and improvements prior to the granting of a certificate to operate. The lien is filed on behalf of each resident of the facility in an amount equal "to the reasonable value of services to be performed". Additionally, while the existing act states that the residents' claim is subordinate to any other lien or encumbrance outstanding at the time of liquidation, the proposed bill provides that the residents' claim is preferred to all liens, mortgages, or other encumbrances attached subsequent to their own. Thus, the residents will be placed in the position of being a secured creditor in the event of liquidation.

Escrow account for entrance fees. A new provision will require that the operator, as a condition for licensure, establish an escrow account for the deposit of any entrance fee received. The funds could

be released from escrow when living units become available for residency or when long-term capital financing has been obtained.

Annual report. The proposed bill will require the operator to file an annual report with the commissioner. The report must contain certified financial statements, updating of the information that is contained in the initial application for a license, and such other information as the commissioner may require. The current act only requires that an annual audit be filed with the board and this is largely for the purpose of determining that reserve requirements are met.

As a means of providing a more detailed explanation of the proposed statutory changes, the following attached copy of the bill offers section-by-section comments and comparisons with the existing law governing life care institutions.

BILL 1

A BILL FOR AN ACT

CONCERNING THE REGULATION OF LIFE CARE INSTITUTIONS.

Bill Summary

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

Places regulatory authority for life care institutions in the division of insurance. Provides remedies for residents of life care institutions by requiring the recording of a lien for their benefit, by requiring specified escrow and reserve funds, and by providing statutory remedies for the rehabilitation of an insolvent or financially unsound provider. Repeals the existing board of examiners of life care institutions.

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

SECTION 1. Article 13 of title 12, Colorado Revised Statutes 1973, 1978 Repl. Vol., as amended, is REPEALED AND REENACTED, WITH AMENDMENTS, to read:

ARTICLE 13

Life Care Institutions

12-13-101. Definitions. As used in this article, unless the context otherwise requires:

(1) "Commissioner" means the commissioner of insurance.

(2) "Entrance fee" means the total of any initial or

12-13-101. Definitions. The act formerly defined "aged person" as a person age 62 or older, and "life care" as care provided to an aged person. The bill deletes the "aged person" definition, and amends "life care" to be services provided to an individual, this change expands the statutory provisions to any life care client, regardless of age.

(1) New definition.

(2) New definition.

deferred transfer to or for the benefit of a provider of a sum of money or other property made or promised to be made as full or partial consideration for the acceptance or maintenance of a specified individual as a resident in a facility.

(3) "Facility" means the place in which a provider undertakes to provide life care to a resident.

(4) "Life care" means care provided, pursuant to a life care contract, for the life of an individual, including but not limited to services such as health care, medical services, board, lodging, or other necessities.

(5) "Life care contract" means a written contract to provide life care to a person for the duration of such person's life conditioned upon the transfer of an entrance fee to the provider of such services in addition to or in lieu of the payment of regular periodic charges for the care and services involved.

(6) "Living unit" means a room, apartment, or other area within a facility set aside for the exclusive use or control of one or more identified residents.

(7) "Provider" means a person holding a certificate of authority issued pursuant to section 12-13-103 who undertakes to provide services in a facility pursuant to a life care contract.

(8) "Resident" means any person entitled pursuant to a life care contract to receive life care in a facility.

(9) "Third party service providers" means any person, other than a provider holding a certificate of authority issued

(3) New definition.

(4) "Medical services" is new to this definition.

(5) New definition. The former definition of "agreement" -- "a written contract providing for the transfer of property conditioned on the furnishing of life care entered into between a prospective resident of a life institution and a certificate holder" -- has been deleted, as has the definition of "certificate holder".

(6) New definition.

(7) New definition replaces the provisions formerly defined under "certificate holder".

(8) Substantially the same as existing definitions.

(9) New definition.

pursuant to section 12-13-103, who contracts with a provider to provide life care services to residents.

12-13-102. Certificate of authority required - application. (1) After July 1, 1981, no person shall construct, acquire, maintain, or conduct a facility for the purpose of offering life care, or enter into a life care contract as a provider, or as a provider modify the terms of an existing life care contract, except pursuant to this article.

(2) To qualify for a certificate of authority to enter into life care contracts with respect to a particular facility, a person shall file an application for a certificate of authority with the commissioner, on certificate of authority application forms provided by the commissioner, which shall include as an exhibit a copy of the proposed form of life care contract to be entered into with residents at each facility. The application shall contain the following information:

(a) The name, business address of the applicant, and any name under which the applicant is doing business;

(b) The name and address of the applicant's agent for service of process in Colorado;

(c) The name, address, and a description of the physical property of the facility;

(d) The terms and conditions of the life care contracts to be used by the applicant, including the services to be provided to residents pursuant to the contract and the fees or charges to be paid by residents, including the method of payment of such

In addition to "aged person", "agreement", and "certificate holder", deleted definitions include "board" (of examiners of life care institutions), "department" (of regulatory agencies), "executive director" (of department), "operator" (administrator of a life care instituion), and "provisional certificate" (permit to offer life care prior to construction or actual operation of an institution).

12-13-102.

(1) Under the existing act, similar provisions to these concern the granting of "provisional certificates" for the construction or acquisition of a facility, or a "certificate" for the maintenance or operation of a facility.

(2) This is new language, vesting permit powers with the Commissioner of Insurance, rather than in the present Board of Examiners of Life Care Institutions. A new provision in the proposed bill states that a copy of the owner's proposed life care contract with residents is to be included with the application for a permit. Presently, the act provides that the standard contract "shall be approved by the board, and a current copy shall be filed with the board", but not that it must be filed with the application. Also new in this proposed bill is the listing of specific information to be contained in the application for a permit. Under the existing act, the contents of the application are determined by the board under their general powers and duties.

Included in the list of specific information to accompany the application is an identification of individuals with financial interest in the entity, and a detailed plan for the accounting of reserve funds.

The application for certificate of authority shall contain:

(a) Name of applicant.

(b) Name of agent.

(c) Facility description.

(d) Terms of a contract -- services to be delivered, fees and charges, method of payment.

fees or charges;

(e) If the applicant is other than an individual, including, but not limited to, a corporation, partnership, or trust:

(I) A statement naming the type of legal entity and listing the interest and extent of such interest of each principal in the entity. For the purposes of this section, "principal" means any person or entity having a ten percent or more financial interest or, if the legal entity is a trust, each beneficiary of the trust holding a ten percent or more beneficial interest.

(II) The names of the members of the board of directors, the trustees, or the managing partners and a statement disclosing whether and to what extent such persons have an interest in any contract to provide any life care services on behalf of the applicant;

(f) The estimated number of residents of the facility to be provided services pursuant to the life care contracts and a statement disclosing the nature and extent of any contracts between the applicant and third party service providers;

(g) A statement of the provisions that have been made or will be made to provide reserve funding or security by the applicant to enable the applicant to fully perform his obligations pursuant to life care contracts, including, but not limited to, the establishment of escrow accounts, accounts in financial institutions, trusts, or reserve funds;

(h) A statement as to whether the applicant was or is

12-13-102(2). Contents of an application for a permit (Con't)
(New provisions)

(e)(I) and (II) - Persons with a management financial interest in the facility.

(f) Number of residents; disclosure of third-party providers.

(g) Reserve funding provisions.

affiliated, or has a contractual relationship, with a religious, charitable, or other nonprofit organization, the extent of any such affiliation or contractual relationship, and the extent to which the nonprofit organization will be responsible for the financial and contract obligations of the applicant;

(i) If the applicant is a subsidiary corporation or the affiliate of another corporation, a statement identifying the parent corporation or the other affiliate corporation, the primary activities of such parent or other affiliate corporation, and the names of the members of the board of directors and officers of such parent or other affiliate corporation;

(j) A description of the business experience of the applicant in the operation of similar facilities, the business experience of third party service providers, and, if the facility will be managed on a day-to-day basis by a corporation or organization other than the applicant, a description of the business experience of the manager in the operation or management of similar facilities;

(k) A statement as to whether the applicant, a principal, a parent or subsidiary corporation, or an affiliate has any pending court action of which it is a party, has had any injunctive or restrictive order of a court of record applied against it, or any suspension or revocation of any state or federal license or permit, any of which arises out of or relates to business activity or health care, including without limitation, actions affecting a license to operate a foster care facility, a health

12-13-102(2) Contents for an application for a permit (Con't)
(New provisions)

(n) Disclosure of affiliation with religions or charitable organizations.

(i) Disclosure of parent or affiliated corporation.

(j) Disclosure of prior business experience of applicant, third-party providers, and managers.

(k) Disclosure of pending court action, injunctions, or other disciplinary actions arising from prior health-related business activity.

care institution, retirement home, or a home for the aged;

(l) A statement of any periodic rates to be initially paid by residents, the method by which such rates are determined, and the manner by which the applicant may adjust such rates in the future. If the facility is already in operation or if the applicant operates one or more similar facilities within this state, the statement shall include tables showing the frequency and average dollar amount of each increase in periodic rates at each such facility for the previous five years or such shorter period as the facility may have been operated by the applicant;

(m) A statement of the terms and conditions under which a life care contract may be canceled by the provider or resident, including any health or financial conditions required for a person to continue as a resident and any conditions under which all or any portion of the entrance fee will be refunded by the provider;

(n) If construction or purchase of the facility has not yet been completed, a statement of the anticipated source and application of the funds to be used in such purchase or construction, including all of the following:

(I) An estimate of the cost of purchasing or constructing and equipping the facility, including such related costs as financing expense, legal expense, land costs, occupancy development costs, and all other similar costs which the applicant expects to incur or become obligated for prior to the commencement of operations;

12-13-102(2) Contents of an application for a permit (Con't)
(New provisions)

(l) Periodic rates to be charged to residents.

(m) Cancellation of life care contracts, refunding of entrance fee.

(n) Sources and uses for applicants capital funds, including --

- costs of facility acquisition

(II) An estimate of the total entrance fees to be received from residents upon completion of occupancy;

(III) A description of any mortgage loan or other long-term financing intended to be used for the financing of the facility, including the date and anticipated terms and costs of such financing;

(IV) An estimate of any funds which are anticipated to be necessary to fund start-up losses and to assure full performance of the obligations of the provider pursuant to life care contracts including, but not limited to, any reserve fund required by the commissioner pursuant to section 12-13-106;

(o) Certified financial statements of the applicant prepared by a certified public accountant as of a date not more than ninety days prior to the date the application is filed, which shall include a balance sheet and income statements for the three most recent fiscal years of the applicant or such shorter period of time as the applicant shall have been in existence. If applicant's fiscal year ended more than ninety days prior to the date of filing there shall also be included an income statement, which need not be certified, covering the period between the date such fiscal year ended and a date not more than ninety days prior to the date the application is filed;

(p) Projected annual income statements for the facility for not less than a five-year period commencing on the date the facility is intended to become operational, if operation of the facility has not yet commenced, or actual income statements for a

12-13-102(2) Contents of an application for a permit (Con't)
(New provisions)

(n) Capital funds (con't)

- funds received from entrance fees
- long-term financing
- funding for anticipated start-up losses; escrowed reserve funds

(o) Applicant's recent financial statements.

(p) Projected annual income or actual past income statements.

period commencing on the first day of the first fiscal year following the most recent year for which a certified financial statement has been provided pursuant to paragraph (o) of this subsection (2). The income statements may be either on an accrual basis or a cash basis but shall use the same accounting system as used in the certified financial statements. If the income statements are on an accrual basis, separate cash flow statements shall also be provided. The statements shall include all of the following:

(I) Beginning cash balance, and, in the event that operation of the facility has not yet commenced, the beginning cash balance shall be consistent with the statement of anticipated source and application of funds described in paragraph (n) of this subsection (2);

(II) Anticipated earnings on cash reserves;

(III) Estimates of net receipts from entrance fees, other than entrance fees included in the statement of source and application of funds required under paragraph (n) of this subsection (2), less estimated entrance fee refunds and a description of the actuarial basis and method of calculation for the projection of entrance fee receipts;

(IV) An estimate of gifts or bequests if any are to be relied on to meet operating expenses;

(V) A projection of estimated income from fees and charges other than entrance fees, showing individual rates presently anticipated to be charged, including a description of the

(p) Income statements (con't)

Statements shall include --

- beginning cash balance

- earnings on cash reserves

- receipts from entrance fees, other than those included in initial capital funding

- gifts or bequests as operating revenue

- income from fees and charges other than entrance fees, anticipated rates to residents, assumptions on cost of subsidized health services.

assumptions used for calculating the effect on the income of the facility of subsidized health services to be provided pursuant to the life care contracts;

(VI) A projection of estimated operating expenses of the facility, including a description of the assumptions used in calculating the expenses, and separate allowances for the replacement of equipment and furnishings and anticipated major structural repairs or additions;

(VII) An estimate of annual payments of principal and interest required by any mortgage loan or other long-term financing;

(q) In the event that the income statements required by paragraph (p) of this subsection (2) indicate that the applicant will have cash balances over and above two months' projected operating expenses of the facility, a description of the manner in which the reserve funds will be invested and the persons who will be making the investment decisions.

(3) The application shall be signed under oath by the president and secretary or, if none, the chief executive officer of the applicant.

(4) A copy of the escrow agreement executed with an escrow agent pursuant to section 12-13-104 shall be recorded as an exhibit to the application.

(5) (a) The life care contract shall provide that any person entering into the contract shall have a period of seven days within which to rescind the life care contract without

12-13-102(2) Contents of an application for a permit (Con't)
(New provisions)

(p) Income statements - items included (Con't)

- estimates of operating, replacement, repair expenses

- estimated payments on long-term debt

(q) Manner of investing cash that exceeds two month's operating expenses.

(3) Application signed under oath.

(New provision)

(4) Escrow agreementsrecorded as exhibits to application.

(New provision)

(5) (a) The contract will allow prospective residents to rescind, without penalty, seven days after either: execution of contract; payment of an initial fee; or receipt of a copy of operator's application for a permit or recent annual report.

(New provision)

penalty or further obligation beginning with the first full calendar day following the last occurring condition below:

(I) Execution of the contract;

(II) The payment of an initial sum of money as a deposit or application fee; or

(III) Receipt of a copy of the provider's application or most recent annual report.

(b) In the event of such rescission, all money or property paid or transferred by such person shall be fully refunded by the provider. No person shall be required to move into a facility until after the expiration of the seven-day rescission period.

(6) The commissioner may charge an applicant a nonrefundable fee not exceeding one hundred dollars for a facility with less than one hundred residents or two hundred dollars for a facility with one hundred or more residents for processing the application filed pursuant to subsection (2) of this section.

(7) Prior to the execution of a life care contract and the transfer of any money or other property to a provider pursuant thereto, the provider shall deliver to the person with whom the life care contract is entered into a copy of the provider's certificate of authority application or most recent annual report as prescribed by section 12-13-107, whichever is most recent.

12-13-103. Issuance, denial, suspension, and revocation of certificate of authority. (1) Upon receipt of a completed application and exhibits and payment of the fee by the applicant

12-13-102. Permit required - application. (Con't)

(5) (b) If prospective resident reciods the contract, full refund must be made. The resident can move in after a seven-day recission period.

(New provision)

(o) Fees charged for processing application.

(New provision)

(7) The prospective resident is to receive a copy of permit application or the annual report prior to execution of a contract or payment of any funds.

(New provision)

and proof of compliance by the applicant with the provisions of sections 12-13-101 to 12-13-106, the commissioner may issue a certificate of authority to the provider allowing the provider to enter into life care contracts with respect to the number of living units and facility described in the application. The commissioner may deny a certificate of authority if he determines, after a review of the application and exhibits, that the applicant or the facility is financially unsound, that the competence, experience, or integrity of the applicant, its board of directors, or its officers are such that it would not be in the interest of the public to issue a certificate of authority, or that the proposed form of life care contract does not comply with section 12-13-113. Any applicant whose application is denied may appeal such decision pursuant to the provisions of article 4 of title 24, C.R.S. 1973.

(2) A certificate of authority issued under this section shall remain in effect, subject to the provisions of this article.

(3) A certificate of authority issued pursuant to this section shall contain, in a prominent location, a statement that the issuance of a certificate of authority pursuant to section 12-13-103 does not constitute approval, recommendation, or endorsement by the commissioner, nor does such a certificate of authority evidence the accuracy or completeness of the information set out in the application or the annual report of the provider.

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12-13-103. Issuance, denial, suspension, and revocation of permit

(1) The applicant is permitted to commence operations, as per application, or certificate can be denied for financial instability, matters of applicant's character or inexperience, or non-compliance of proposed life care contract with provisions of section 12-13-133.

Applicant can appeal denial under the provisions of the "Administrative Procedures Act".

(These reasons for denial of a certificate of authority do not exist in the current act)

(2) Certificate of authority, when issued, to remain in effect indefinitely.

(Under current provisions, certificate is effective for one year)

(3) Notice to be posted that issuance of permit does not constitute endorsement.

(New provision)

(4) No certificate of authority shall be transferable, and no certificate of authority issued pursuant to this article shall be deemed to have value for sale or exchange as property. No provider shall sell or transfer ownership of the facility, or enter into a contract with a manager for the facility, unless the commissioner approves such transfer or employment contract.

(5) The commissioner, after notice and hearing, may suspend or revoke a certificate of authority for violation of any of the provisions of this article or any rule or regulation promulgated by the commissioner pursuant to this article.

(6) The commissioner shall ensure that services offered by providers pursuant to life care contracts shall not cease due to any revocation or suspension of a certificate of authority, but shall protect against such interruption of services by exercising his powers or remedial authority as provided in section 12-13-108 (1).

t12-13-104. Escrow account for entrance fees. (1) As a condition for the issuance of a certificate of authority pursuant to section 12-13-103, the commissioner shall require that the provider establish an escrow account with a third party approved by the commissioner which provides that all of any entrance fee received by the provider prior to the date the resident is permitted to occupy his or her living unit in the facility be placed in escrow with a bank, trust company, or other escrow agent located in Colorado and approved by the commissioner, subject to the condition that such funds may be released only as

12-13-103. Issuance, denial, suspension, and revocation of permit (Con't)

(4) Permit is non-transferable; owner to obtain commissioner's approval of pertinent contract prior to sale or transfer of the facility, or prior to employment of a manager.

(Similar to existing provision)

(5) Permit may be revoked or suspended by commissioner.

(Similar to existing provisions, which currnetly have the additional grounds for suspension or revocation of certificate for failure to meet reserve requirements.)

12-13-104 (The provisions of this section are new)

(1) Owner is required to establish an approved third-party escrow account for safekeeping of any entrance fee prospective residents prior to occupany; entrance fees in escrow released when--

follows:

(a) If the entrance fee applies to a living unit which has been previously occupied in the facility, the entrance fee shall be released to the provider at such time as the living unit becomes available for occupancy by the new resident and is in compliance with local government regulations applicable to living units;

(b) If the entrance fee applies to a living unit which has not previously been occupied by any resident, the entrance fee, or that portion of the entrance fee not to be held in escrow pursuant to section 12-13-106, shall be released to the provider at such time as the commissioner is satisfied that all of the following conditions exist:

(I) Construction or purchase of the facility has been substantially completed, and an occupancy permit covering the living unit has been issued by the local government having authority to issue such permits;

(II) A commitment has been received by the provider for any permanent mortgage loan or other long-term financing described in the statement of anticipated source and application of funds submitted by the provider as part of its certificate of authority application, and any conditions of the commitment prior to disbursement of funds thereunder have been substantially satisfied;

(III) Aggregate entrance fees received or receivable by the provider pursuant to binding life care contracts, plus the

12-13-104, Escrow account for entrance fees (Con't)

(The provisions of this section are new)

(1) Entrance fee in escrow released when (con't)

(a) previously occupied unit becomes available to new resident

(b) new unit is available to new resident, and-

- new facility is ready for occupancy, and

- long-term financing has been obtained, and

- entrance fees from all binding contracts plus proceeds from long-term financing equal 90 percent of initial capital costs and 90 percent of estimated start-up losses.

anticipated proceeds of any first mortgage loan or other long-term financing commitment are equal to not less than ninety percent of the aggregate cost of constructing or purchasing, equipping, and furnishing the facility and not less than ninety percent of the funds estimated in the statement of anticipated source and application of funds submitted by the provider as part of its certificate of authority application to be necessary to fund start-up losses and assure full performance of the obligations of the provider pursuant to life care contracts.

(2) If the funds in an escrow account required to be established under subsection (1) of this section are not released within such time as provided by rules and regulations issued by the commissioner, then such funds shall be returned by the escrow agent to the persons who had made payment to the provider.

(3) An entrance fee held in escrow may be returned by the escrow agent to the person or persons who had made payment to the provider at any time upon receipt by the escrow agent of notice from the provider that such person is entitled to a refund of the entrance fee.

(4) Nothing in this section shall be interpreted as requiring the escrow of any nonrefundable application fee, designated as such in the life care contract received by the provider from a prospective resident.

12-13-105. Recording of lien by commissioner. (1) The commissioner shall, as a condition to granting a certificate of authority to an applicant, record with the county recorder of any

12-13-104. Escrow account for entrance fees (Con't)

(The provisions of this section are new)

(2) Funds in escrow, if not released within the time established by rule and regulation, shall be returned to prospective resident.

(3) Refunds of entrance fees in escrow may be made to prospective resident upon notice to the owners.

(4) Escrow not required of nonrefundable application fees from prospective residents.

12-13-105

(1) Notice of lien to be filed, by commissioner, on behalf of all life care residents to secure performance of contracts. (Under existing statute, a life care agreement is deemed a preferred claim against the operators assets in the event of liquidation. Currently, the board may record a notice of lien on behalf of residents "when necessary to secure the performance of all obligations".)

county a notice of lien on behalf of all residents who enter into life care contracts with the applicant to secure performance of the provider's obligations to residents pursuant to life care contracts.

(2) From the time of such recording, there exists a lien for an amount equal to the reasonable value of services to be performed under a life care contract in favor of each resident on the land and improvements owned by the provider, not exempt from execution, which are listed in the notice of lien filed pursuant to subsection (3) of this section and which are located in the county in which the notice of lien is recorded.

(3) The lien shall be perfected by the commissioner by executing by affidavit the notice and claim of lien, which shall contain:

(a) The legal description of the lands and improvements to be charged with a lien;

(b) The name of the owner of the property affected;

(c) A statement providing that the lien has been filed by the commissioner pursuant to this section.

(4) The lien may be foreclosed by civil action.

(5) Any number of persons claiming liens against the same property pursuant to this section may join in the same action. If separate actions are commenced, the court may consolidate such actions. The court shall, as part of the costs, allow reasonable attorney's fees for each claimant who is a party to the action.

(6) In a civil action filed pursuant to this section, the

12-13-105. Recording of lien by commissioner (Con't)

(2) Lien in favor of each resident on provider's land and improvements to be valued equal to reasonable services under life care contract. (This is similar to existing language, but with the addition of the "reasonable value of services" provision.)

(3) Lien shall contain--

(a) description of land and improvements charged with a lien

(b) name of property owner

(c) statutory citation providing for lien
(These required contents of the lien are additions to the exisiting statute).

(4) Forclosure by civil actions.
(New provision)

(5) Action by lien holders may be consolidated.
(New provision)

judgment shall be given in favor of each resident having a lien who has joined in the foreclosure action for the amount equal to the reasonable value of services to be performed under a life care contract in favor of each resident. The court shall order the sheriff to sell any property subject to the lien at the time judgment is given, in the same manner as real and personal property is sold on execution. The lien for the reasonable value of services to be performed under a life care contract shall be on equal footing with claims of other residents. If a sale is ordered and the property sold and the proceeds of the sale are not sufficient to discharge all liens of residents against the property, the proceeds shall be prorated among the respective residents.

(7) The liens provided for in this section are preferred to all liens, mortgages, or other encumbrances upon the property attaching subsequently to the time the lien is recorded and are preferred to all unrecorded liens, mortgages, and other encumbrances. The amount secured by any lien having priority to the lien filed pursuant to this section may not be increased without prior approval of the commissioner.

(8) The commissioner shall file a release of the lien upon proof of complete performance of all obligations to residents pursuant to life care contracts.

(9) The commissioner may subordinate any lien filed pursuant to this section to the lien of a first mortgage or other long-term financing obtained by the provider, regardless of the

(6) Judgement in civil forclosure action shall be equal to value of reasonable services under life care contract; proceeds from immediate sale of property, if insufficient to discharge all liens, shall be prorated.

(New provision)

(7) Liens in favor of residents preferred to all other claims subsequent to filing of the lien, and preferred to all unrecorded claims. Proceeds from liens with priority to residents' not increased without commissioner's approval. (Existing statute provides that resident's "preferred claim" is subordinate to any secured lien or encumbrance outstanding at the time of liquidation If a lien is filed by the board, the lien will not take precedence over any recorded lien or encumbrance secured by the property.)

(8) Lien released upon proof of complete performance. (In the existing act, the board will release the lien upon proof of performance, upon the filling of a fidelity bond by the operator, or if the board deems the lien no longer necessary to secure performance.)

(9) Residents' lien may be subordinated to first mortgage at any time.

(New provision)

time at which the subsequent lien attaches.

12-13-106. Reserve requirements. (1) Any provider shall maintain reserves covering obligations under all life care agreements. The reserves shall be equivalent to sixty-five percent of the amount of any advance deposit, entrance fee, or other lump sum initial payment made by each resident of the facility. The deposit shall then be amortized for the purposes of these reserves over the first five-year period of each such resident's residency, on a straight-line basis, but at no time during the period of an agreement shall the reserves be less than thirty percent of the original reserve requirement.

(2) The reserves shall consist of the following:

(a) Savings accounts or certificates of deposit in state or national banks located in this state which are members of the federal deposit insurance corporation;

(b) Savings accounts or savings certificates in state or federal savings or loan associations located in this state which are members of the federal savings and loan insurance corporation;

(c) Notes receivable secured by first deeds of trust and first mortgages;

(d) Bonds and stocks selected from an approved list, as determined by the commissioner. If stocks, bonds, and securities that are not on the approved list are part of the reserves, and if they are to be retained as part of the reserves, it shall not be necessary that such unapproved stocks, bonds, and

12-13-106, Reserve requirements

(This subsection (2) is identical to existing language, except where noted. "Commissioner" has been substituted for "board" throughout.)

(2) Reserves to consist of --

(a) Savings and certificates of deposit, insured by FDIC .

(b) Savings and certificates of deposit, insured by FSLIC.

(c) Secured notes.

(d) Stocks and bonds, under noted conditions.

securities be disposed of immediately, but they shall be disposed of in accordance with rules promulgated pursuant to this article, which disposal shall be accomplished in a gradual manner so as to avoid loss to providers. Securities which, although not on the approved list, should be retained in the reserve for reasons acceptable to the commissioner may be retained with the specific approval of the commissioner.

(e) Real estate used to provide care and housing for residents, or equities therein, owned by the provider, to the extent of seventy-five percent of the net value thereof. Values shall be fixed by an appraiser who is a member of an institute of real estate appraisers, or its equivalent.

(f) Furniture and equipment situated in property used to provide care and housing for residents, to the extent of fifty percent of the net value thereof, the value to be the cost thereof reduced by depreciation.

(g) Real estate or equities therein owned by the provider as an investment, the rents from which are used to discharge obligations to the residents or to reinvest as a part of the reserves;

(h) Investment certificates or shares in open-end investment trusts whose management has been managing a mutual fund registered under the federal "Investment Company Act of 1940" or whose management has been registered as an investment adviser under the federal "Investment Advisers Act of 1940", and in either case currently has at least one hundred million

12-13-106. Reserve requirements (Con't)

(2) Reserve requirement to consist of - (Con't)

(Identical to existing provisions, except where noted)

(e) Real estate owned by provider, to the extent of 75% of its net value. (Existing provision is "to the extent of one hundred percent of its net value". Current provisions also allow that "such percentage shall be reduced by two percent per year to a minimum of fifty percent of the net value thereof.")

(f) Furniture and equipment, to the extent of 50 percent of net value. (Current provisions are "to extent of one hundred percent of net value", and that percentage "shall be reduced by two percent per year to a minimum of twenty-five percent of the net value thereof.")

(g) Investment real estate owned by provider.

(h) Mutual funds.

dollars under its supervision, is qualified for sale in Colorado, has at least forty percent of its directors or trustees not affiliated with the fund's management company or principal underwriter or any of their affiliates, is registered under the federal "Investment Company Act of 1940", and is a fund listed as qualifying under rules maintained by the secretary of state in cooperation with the division of insurance.

(3) At least ten percent of the reserves necessary to maintain all life care contracts shall consist of listed bonds, stocks, savings accounts, savings certificates or certificates of deposit in state or national banks or in savings and loan associations located in this state.

(4) Any person or organization which entered into life care contracts prior to January 1, 1974, but which was not required prior to such date to obtain a license, is not required to maintain reserves covering obligations assumed under any such contract entered into prior to January 1, 1974.

(5) The reserves required by this section shall be treated as a liability on financial statements of the provider.

12-13-107. Annual report. (1) Each provider shall file an annual report, accompanied by a fee of one hundred dollars, for a facility with less than one hundred residents or two hundred dollars for a facility with one hundred or more residents, with the commissioner within ninety days after the end of its fiscal year which contains the information required by section 12-13-102 (2), certified financial statements for each facility, and such

12-13-106. Reserve requirements (Con't)

(3) Ten percent of reserves to consist of cash or securities. (Identical to existing provision.)

(4) Contracts pre-dating 1974 not required to meet reserve requirement. (Identical to existing provision)

(5) Reserves treated as liability on financial statements.

(New provision)

12-13-107

(The provisions in this section are new)

(1) Annual report, accompanied by a fee, to be filed with commissioner.

other information as may be required by the commissioner. The annual report shall be made on forms provided by the commissioner. The annual report and any amendment thereto shall be signed under oath by the president and secretary or, if none by the chief executive officer of the provider.

(2) A provider shall amend its annual report on file with the commissioner, without the payment of any additional fee, if an amendment is necessary to prevent the report from containing a material misstatement of fact or omission of a material fact.

(3) A provider shall make its annual report available to residents upon request.

(4) The failure to file an annual report within the time prescribed in subsection (1) of this section shall operate as an automatic revocation of the provider's certificate of authority.

12-13-108. Rehabilitation of provider. (1) If at any time the commissioner receives notice from the escrow agent that the provisions of section 12-13-106 have not been complied with, or at any other time when the commissioner has reason to believe that the provider is insolvent, is in imminent danger of becoming insolvent, is in a financially unsound or unsafe condition, or that its condition is such that it may otherwise be unable to fully perform its obligations pursuant to life care contracts, the commissioner shall, with respect to providers, have the powers set forth in part 4 of article 3 of title 10, C.R.S. 1973, providing remedial authority in instances of insurance company delinquencies. In lieu of exercising those powers, the

12-13-107. Annual report (Con't)

(The provisions of this section are new)

(2) Provider may amend annual report after its filing.

(3) Annual report available to residents.

(4) Failure to file annual report results in automatic revolation of of permit

12-13-108. (The provisions of this section are new.)

(1) If reserve requirements are violated, or the commissioner suspects the provider's insolvency or financial instability, the commissioner is empowered to exercise the remedial measures available in instances of insurance company delinquencies. Alternatively, the commissioner may petition the district court to assume management and possession of the facility for the purposes of rehabilitation.

commissioner may, through the attorney general, apply to the district court in the county in which the provider's facility is located for an order directing the commissioner to assume management and possession of the provider's facility and to rehabilitate the provider to enable it to fully perform its obligations pursuant to life care contracts. After giving notice to the provider, the court shall act upon the application, and any objection to the petition shall be filed with the court within the time prescribed by such notice. For the purposes of this section, a provider is deemed insolvent when its admitted assets are less than all of its liabilities, excluding from such liabilities the aggregate amount of its outstanding capital stock.

(2) If the court, upon hearing, finds that the provider is insolvent, is in imminent danger of becoming insolvent, is in a financially unsound or unsafe condition, or that its condition is such that it may otherwise be unable to fully perform its obligations pursuant to life care contracts, the court shall issue an order directing the commissioner to take possession of the property of the provider and to conduct the business thereof and to take such steps toward removal of the causes and conditions which have made rehabilitation necessary, as the court may direct. The order shall include a provision directing the issuance of a notice of the rehabilitation proceedings to the residents at such facility and to such other interested persons as the court shall direct.

12-13-104, Rehabilitation of Provider (Con't)
(The provisions of this section are new)

(2) If it determines financial instability of the provider, the court may direct the commissioner to take possession and conduct the business of the facility. Residents are to be notified of the court order.

(3) Appointment of the commissioner to rehabilitate a provider shall authorize the commissioner to:

(a) Take possession of and preserve, protect, and recover any assets, books, and records or property of the provider, including claims or causes of action belonging to or which may be asserted by the provider and to deal with such property in his own name in the capacity as commissioner, and purchase at any sale any real estate or other asset upon which the provider may hold any lien or encumbrance or in which it may have an interest;

(b) File, prosecute, defend, compromise, or settle any suit or suits which have been filed or which may thereafter be filed by or against such provider which are deemed by the commissioner to be necessary to protect the provider or the residents or any property affected thereby;

(c) Deposit and invest any of the provider's available funds;

(d) Pay all expenses of the rehabilitation;

(e) Exercise such other powers and duties as may be provided by order of the court;

(f) Appoint managers, supervisors, or employees necessary to properly manage and operate the provider and the provider's facility;

(g) With the prior approval of the court, sell, exchange, lease, mortgage, or otherwise dispose of any property of the provider by public sale, bidding, or otherwise;

(h) With the prior approval of the court, borrow money with

12-13-108. Rehabilitation of provider (Con't)
(The provisions of this section are new)

(3) In rehabilitation of a provider, the commissioner is authorized to -

(a) Take control of financial affairs ;

(b) Undertake the resolution of a court action ;

(c) Manage provider's funds;

(d) Pay expenses ;

(e) Excercise court-ordered powers;

(f) Appoint necessary personnel ;

(g) Dispose of provider's property, with court approval;

(h) Borrow money ;

or without security for the purpose of facilitating the rehabilitation of the provider;

(i) Perform all duties of the provider;

(j) Reject any executory contract to which the provider is a party;

(k) Withdraw any sums remaining in the escrow account established pursuant to section 12-13-104 for the purpose of rehabilitating the provider's facility.

(4) The court may at any time during a rehabilitation proceeding issue such other instructions or orders as are deemed necessary to aid the commissioner in the rehabilitation proceeding.

(5) The commissioner, or any interested person upon due notice to the commissioner, at any time may apply to the court for an order terminating the rehabilitation proceedings and permitting the provider to resume possession of its property and the conduct of its business, but no such order shall be granted except when, after a full hearing, the court has determined that the purposes of the proceeding have been fully accomplished and that the facility can be returned to the provider's management without further jeopardy to the residents of the facility, creditors, owners of the facility, and to the public. An order terminating the rehabilitation proceeding shall be based upon a full report and accounting by the commissioner of the conduct of the provider's officers during the rehabilitation and of the provider's current financial condition.

12-13-108. Rehabilitation of provider (Con't)
(The provisions of this section are new)

(i) Perform all duties ;

(j) Reject provider's contracts ;

(k) Withdraw escrow funds .

(4) Court may vest commissioner with additional powers .

(5) Commissioner or any other person may petition court for termination of rehabilitation, and to permit provider to resume possession and management.

(6) If at any time the commissioner deems that further efforts to rehabilitate the provider would be useless, he may report to the court and apply for an order of liquidation and dissolution pursuant to article 26 of title 7, C.R.S. 1973, if the provider is a corporation, or may apply for other appropriate relief for dissolving the provider and winding up its affairs. An order directing the liquidation or dissolution of the provider shall act as a revocation of the provider's certificate of authority issued pursuant to section 12-13-103.

(7) In connection with the rehabilitation proceedings, the commissioner may appoint one or more special deputy directors of insurance to act for him and may employ such counsel, clerks, or assistants as he deems necessary. The compensation of the special deputies, counsel, clerks, or assistants and any expenses of taking possession of the provider's facility and of conducting the proceedings shall be set by the commissioner, subject to approval of the court, and shall be paid out of the funds of assets of the provider.

12-13-109. Examination. The commissioner may conduct an examination of the affairs of any provider as often as he deems it necessary for the protection of the interests of the people of this state and, for this purpose, shall have the powers set forth in section 10-1-110, C.R.S. 1973, with respect to examinations of insurers. Providers shall maintain copies of their books and records in Colorado to provide access for the purposes of this article.

12-13-108, Rehabilitation of provider (Con't)
(the provision of this section are new)

(6) If commissioner deems rehabilitation to be useless, he may apply for court-ordered liquidation and dissolution.

(7) Commissioner may appoint special deputies to act for him in rehabilitation proceeding.

12-13-110. Rules and regulations. The commissioner may promulgate reasonable rules and regulations in accordance with article 4 of title 24, C.R.S. 1973, for effectuating any provision of this article.

12-13-111. Violation. After July 1, 1981, any person acting in the capacity of a provider who enters into a life care contract, or extends the term of an existing life care contract, without first having been issued a certificate of authority by the commissioner or without otherwise acting in compliance with the provisions of this article is guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not more than one thousand dollars, or by imprisonment in the county jail for not more than six months, or by both such fine and imprisonment.

12-13-112. Article does not apply to facilities licensed by department of health. The provisions of this article shall not apply to any hospital or other facility which the department of health is authorized to license pursuant to part 1 of article 1 and part 1 of article 3 of title 25, C.R.S. 1973.

12-13-113. Life care contract - content. (1) Each life care contract shall:

(a) Show the value of all property transferred, including but not limited to donations, subscriptions, fees, and any other amounts initially paid or payable by or on behalf of the prospective resident;

(b) Show all the services which are to be provided by the

12-13-110.

The commissioner may promulgate rules and regulations. (Under the existing act, the board of examiners of life care institutions was so empowered as one of their general powers and duties.)

12-13-111.

The penalty for attempting to provide life care without a permit is a fine of not more than $1,000, or imprisonment in a county jail for not more than six months, or both.

(Though the language of this section is different than the existing statute, the sanctions are the same.)

12-13-112 (This section is new)

The provisions of this act do not apply to facilities licensed by the Department of Health. Included in these licensed facilities are general hospitals, phychiatric hospitals, community hospitals, rehabilitation centers, community mental centers, and nursing homes.

12-13-113. (Most of the provisions of this section exist in the current act. New provisions are found in paragraphs (1)(c) and (1)(f))

(1) Contracts with residents will contain the following information -

(a) Initial payments by resident ;

(b) Services to be provided to resident;

provider to the prospective resident, including, in detail, all items which the prospective resident will receive, such as board, room, clothing, incidentals, medical care, transportation, and burial, and whether the items will be provided for a designated time period or for life and the monthly charge for such services;

(c) Be accompanied by a financial statement showing in reasonable detail the financial condition of the provider, which shall be furnished to the prospective resident;

(d) Specify the monthly service fee and whether such fee is subject to adjustment;

(e) Explicitly state what rights, if any, a resident will have to participate either individually or as part of a group of residents in management decisions affecting the facility;

(f) Comply with the provisions of section 12-13-102 (5).

(2) A copy of the standard life care contract entered into between the provider and prospective residents shall be approved by the commissioner before a certificate of authority is issued to the provider.

12-13-114. Advertisements and solicitations of life care contracts - requirements. Any report, circular, public announcement, certificate, or financial statement, or any other printed matter or advertising material which is designed for or used to solicit or induce persons to enter into any life care contract, and which lists or refers to the name of any individual or organization as being interested in or connected with the person, association, or corporation to perform the contract,

12-13-113. Life Care Contract (Con't)

(1) Contract will contain - (Con't)

(c) Provider's financial statement ;

(d) Monthly service fees, and whether it is adjustable ;

(e) Resident's opportunity to participate in management decisions ; (This is a new provision)

(f) The contract will comply with the provision that residents will be offered the opportunity to rescind the contract within seven days. (This is a new provision)

(2) The standard contract must be approved by commission before a certificate is issued. (The existing statute provides that the "agreement" (contract) will be approved by the board and a current copy filed with the board. The existing agreement is required to contain the information listed in (1)(a) through (d), above. Currently, the board may be assisted by the Division of Insurance in evaluating any existing contract.

12-13-14.

Any advertisement by a life care organization must disclose the financial interests in the organization of persons whose name is used in the advertisement or solicitation.

(This provision exists in the current act. An additional existing provision, not contained in this bill, states that anyone assisting in the distribution of advertising material which violates this disclosure provision is guilty of a misdemeanor.)

shall clearly state the extent of financial responsibility assumed by that individual or organization for the person, association, or corporation and the fulfillment of its contracts.

12-13-115. Injunction against violations - notice of deficiencies - prosecution. (1) The commissioner may bring an action, through the attorney general, to enjoin the threatened violation or continued violation of the provisions of this article, including the operation of a facility without a certificate of authority, or of any of the rules promulgated pursuant to this article, in the district court for the county in which the violation occurred or is about to occur. Any proceeding under the provisions of this section shall be subject to the Colorado rules of civil procedure; except that the commissioner shall not be required to allege facts necessary to show or tending to show the lack of an adequate remedy at law or to show or tending to show irreparable damage or loss.

(2) At least thirty days prior to the filing of an action against a certificate of authority holder under subsection (1) of this section, the commissioner shall serve the certificate of authority holder with a written notice specifying each deficiency in the facility and the violation or continued violation by the provider of this article or any of the rules and regulations promulgated pursuant thereto. No restraining order shall be issued in such action.

(3) Upon application by the commissioner, the attorney general or the district attorney of any judicial district in this

12-13-115. Injunction against violations.

(1) Commissioner may enjoin actual or threatened violations of this article. (This subsection (1) is identical to existing statute, except that the action is undertaken by the commissioner, rather than the board, and that he shall act through the Attorney General.)

(2) Prior to any court action, the provider will be given 30 days written notice. (This provision exists in the current act.)

(3) Prosecution of violations of this article will be by the Attorney General or a district attorney. (This provision exist in the current act)

state shall institute and prosecute an action for the criminal violation of any provision of this article.

12-13-116. Local regulations. The provisions of this article shall not prevent local authorities of any county, city, town, or city and county, within the reasonable exercise of the police power, from adopting rules, by ordinance or resolution, prescribing standards of sanitation, health, and hygiene for facilities which are not in conflict with the provisions of this article or the rules adopted by the commissioner pursuant thereto, and requiring a local health permit for the maintenance or conduct of any such facility within such county, city, town, or city and county.

12-13-117. Name change not to affect rights or obligations. The change of name of the board designated prior to July 1, 1978, as the board of examiners of institutions for aged persons to the board of examiners of life care institutions shall not impair the legal effect of any statute designating such board by any other name nor any property rights acquired or obligations incurred by such board prior to July 1, 1978. Nor shall the designation of the commissioner impair the legal effect of any statute relating to the board of examiners of life care institutions concerning property rights acquired or obligations incurred by such board prior to July 1, 1981. A facility or provider licensed by the state prior to July 1, 1981, shall be subject to the provisions of this act when its certificate is subject to renewal.

SECTION 2. 10-1-108, Colorado Revised Statutes 1973, as

12-13-116

Local units of government may adopt provisions concerning life care not conflicting with this act or the pursuant rules and regulations. (This provision exists in the current act).

12-13-117

This "saving clause" retains the legal effect of prior versions of this statute. (An addition to the existing section is the designation of the Commissioner of Insurance as assuming responsibility for administering this act. Another addition is the provision that existing facilities and providers are subject to this act upon renewal of their existing certificate).

amended, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

10-1-108. Duties of commissioner - reports - publications - disposition of funds. (13) It is the duty of the commissioner to administer the provisions of article 13 of title 12, C.R.S. 1973, relating to life care institutions. All proceedings of the commissioners shall be conducted in accordance with article 4 of title 24, C.R.S. 1973. The commissioner shall submit an annual report to the commission on aging concerning the status of the life care industry.

SECTION 3. Repeal. 24-34-104 (4.1)(b)(II), Colorado Revised Statutes 1973, is repealed.

SECTION 4. Appropriation. There is hereby appropriated, out of any moneys in the state treasury not otherwise appropriated, to the division of insurance in the department of regulatory agencies, the sum of thirty-two thousand seven hundred thirty-two dollars ($32,732), or so much thereof as may be necessary, for the implementation of this act, for the fiscal year beginning July 1, 1981.

SECTION 5. Effective date. This act shall take effect July 1, 1981.

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.

10-1-108

This new subsection adds the responsibility for administering the act to the existing duties of the Commissioner of Insurance.

Repeal

This amendment repeals the "sunset review" for the continuation of the Board of Examiners of Life Care Institutions.

APPENDIX

INVENTORY OF RURAL HEALTH PROGRAMS

The following will provide information regarding programs sponsored by state agencies which offer services impacting upon rural health matters in Colorado. Some programs and organizations which affect rural health, but are responsible for health services of a more general nature on a statewide basis, are not included. Examples of these exclusions are services for the developmentally disabled and mental health programs, and advisory councils such as the Health Facilities Review Council, Advisory Council on Emergency Medical Services, and the Health Facilities Authority.

University of Colorado Health Sciences Center

Family Practice Training. The program provides for a three-year residency to train doctors in a wide range of medicine so that they may provide medical care for all members of the family and meet most of their medical needs. This program operates two family medicine residency programs in conjunction with the University of Colorado Health Sciences Center -- The University-based program at the A.F. Williams Family Medicine Center near the medical school, and the community-based program in conjunction with The Colorado State Hospital and St. Mary-Corwin Hospital in Pueblo.

In addition to these two UCHSC sponsored programs, there are an additional five state-funded family practice training programs, all of which are affiliated with private hospitals:

St. Joseph's Hospital -- Denver
Mercy Hospital -- Denver
Weld County General Hospital -- Greeley
Poudre Valley Hospital -- Ft. Collins
St. Mary's Hospital -- Grand Junction

Students in the training program rotate through internships in a variety of primary care fields in their hospital training, as well as treating patients as the primary physician in free-standing clinics, which are a feature of all the family practice training programs.

Funding:

Funding data for these programs can be found in Appendix A.

Service Area:

See attached Map #1

The Advisory Commission on Family Medicine, created in 1977, is made up of the directors of each of the above training programs, five consumer members, the dean of the medical school, and a representative of the Colorado Academy of Family Physicians (which funds the activities of the commission). The commission's purpose is to assure high standards of family medicine, to identify areas of the state underserved by family physicians, to monitor the state's family medicine residency programs, and to recommend to the General Assembly appropriate funding for the programs.

SEARCH (Statewide Educational Activities for Rural Colorado's Health). The SEARCH program is based at the University of Colorado Health Services Center (UCHSC) and was created in 1977 in an effort to increase the number of health professionals choosing to practice in rural areas, and to help retain professionals already practicing in rural areas. Additionally, it seeks to improve health manpower education, the geographic and specialty distribution of health manpower, and health services in Colorado by decentralizing the educational process.

The program is coordinated through four Area Health Education Centers (AHEC) -- the Centennial AHEC in Greeley; Southeastern Colorado AHEC in Pueblo; the San Luis Valley AHEC in Alamosa; and Western Colorado AHEC in Grand Junction. It is a statewide educational network serving 51 of Colorado's 63 counties. Each AHEC is a legally incorporated, non-profit agency managed by a regional board of directors which hires a staff and sets priorities for health manpower education within its region, under a contract with the UCHSC.

The goals of the program are to: improve the professional environment of rural communities by increasing access to continuing education opportunities; provide health consultation services through the AHEC's to the local professional community; bring the resources of the UCHSC to rural areas; and attract health professionals to rural areas by providing educational and clinical experiences in rural settings.

Funding:

	FY 1979-80	FY 1980-81
General Fund	$ 125,000	$ 198,650
Federal Funds	1,400,000	1,550,000
	$1,525,000	$1,748,150

Service Area: 51 counties -- See attached Map #2

Mountain/Plains Outreach Program (M/POP). Also known as the Community Medical Program, M/POP was formed in 1976 to provide support services to rural and urban physicians in a network of primary care practice sites. The program aims to increase primary care in underserved areas, while at the same time improving the backup services available to a primary care physician in an isolated area. It seems to bring urban resources to rural areas through a well-organized network of cooperative organizations and responsive personnel.

The program involves the cooperative efforts of the University of Colorado Health Sciences Center (Departments of Preventative Medicine and Comprehensive Health Care, Family Medicine, and Nursing), Rose Medical Center, Community Electrocardiographic Interpretative Service, department of Health, and the CSU Extension Service.

Funding:

This data includes only state and federal funds. Other resources, primarily in the form of in-kind services, are provided by the UCHSC and Rose Medical Center.

	FY 1978-79	FY 1979-80	FY 1980-81
General Fund	$ 120,131	$ 129,945	$ 130,295
Federal Funds	196,370	248,224	218,623

Service Area: Primary care sites: Central City, Akron, Pagosa Spring, Lafayette, Sterling, Brighton, Glenwood Springs, Aurora, Commerce City

Demonstration sites: Bailey, Haxton, Julesberg, Denver

See attached Map #3

School of Nursing. The School of Nursing administers a nursing master's degree program which provides training to master's degree students in their own geographic area. Master's degree nurses are apparently needed in order to teach nursing, and due to the shortage of such individuals, many rural colleges are experiencing a shortage of qualified nursing faculty.

The School of Nursing also works in conjunction with the SEARCH program, which helps provide the school with resources for: continuing education to rural nurses; a rural clinical rotation for baccalaureate nursing students; and travel for master's program students. The school's rural health efforts are funded on a cash basis through tuition fees or are grant supported.

Department of Health

Community public health nurses. Utilizing federal funds, the Department of Health pays approximately one-fourth of the salaries of the local community nurses in 41 counties without organized health departments. The remainder of the nurses' salaries are paid by county funds. In these counties, community nurses carry out a number of functions including the prevention of illness, disability, and identification of health problems and assistance to persons in obtaining medical care.

Funding:

	FY 1978-79	FY 1979-80	FY 1980-81
Federal funds	$ 204,030	$ 216,431	$ 251,287

Service Area: See attached Map #4

Nursing consultant services. This program is an adjunct to the community public health nurse program described above. The Department contracts with these same 41 counties to supervise and direct the activities of the community health nurses; acts as a recruitment agency for these counties; and provides other administrative services to these nurses.

Funding:

	FY 1978-79	FY 1979-80	FY 1980-81
General Fund	$ 194,695	$ 194,530	$ 231,286
Federal Funds	196,461	213,495	237,451
	$ 391,156	$ 408,025	$ 468,737

Service Area: See attached Map #4

Public health sanitarians. The Department of Health also pays 35 percent of the salaries of sanitarians, who conduct food service inspections and perform other environmental health duties in 10 rural counties (the county pays the other 65 percent of the salary).

Funding:

	FY 1978-79	FY 1979-80	FY 1980-81
General Fund	$ 32,910	$ 34,550	$100,696
Federal Funds	29,056	29,056	11,456
	$ 61,966	$ 63,606	$112,152

Service Area:	14 rural counties	13 rural counties	10 rural counties

See attached Map #4

Local and regional boards of health. Section 25-1-516, C.R.S. 1973, requires the Department of Health to provide support on a per capita basis of $1.14 to assist local departments of health. Local departments of health perform a wide variety of environmental health duties, including disease control, collection of vital statistics, distribution of emergency medical supplies, etc.

Funding:

	FY 1978-79	FY 1979-80	FY 1980-81
General Fund	$2,305,502	$2,527,586	$2,755,148
Federal funds	98,526	98,526	98,526
	$ 2,404,108	$ 2,626,112	$ 2,853,674

Service Area: See attached Map #4

Emergency medical services. The Department of Health assists local governments in planning and implementing emergency medical services in local areas, pursuant to S.B. 454 passed in 1977. This program also includes the provision of a WATS telephone line ot the Poison Control Center.

Funding:

	FY 1978-79	FY 1979-80	FY 1980-81
General Funds	$ 20,000	$ 20,800	$ 21,032
Cash Funds (Division of Highway Safety)	68,093	72,239	77,677
(Energy Impact Funds)	--	21,000	22,974
Federal Funds	$ 934,363	$1,123,686	$1,076,433
FTE	10	13.7	15.8

Service Area: See attached Map #5

Women, Infants, and Children (WIC) program. This program provides nutritious foods to low income pregnant and nursing women, infants and youngsters. All of the monies are apparently being spent outside of the City and County of Denver.

Funding:

	FY 1978-79	FY 1979-80	FY 1980-81
Federal Funds	$4,176,315	$5,670,161	$8,370,838

Children and youth project. This program provides comprehensive health services to children (up to age 18) of low income families in Adams, Arapahoe, Denver, Douglas, Las Animas and Huerfano counties. This program is part of a larger federal program which also includes a maternity and infants project conducted in the Metropolitan Denver area.

	FFY 1980-79	FFY 1979-80	FFY 1980-81
Federal Funds	$1,691,183	$1,708,266	$1,743,129

Rural Delivery Program. This program transfers funds from the budgets of Colorado General Hospital and Denver General Hospital for the purpose of providing the delivery costs of obstetric patients at local hospitals who otherwise would have delivered their children at Colorado General or Denver General Hospitals.

Funding:

	FY 1978-79	FY 1979-80	FY 1980-81
General Fund			
Colorado General Diversion	$ 75,000	$237,776	$ 470,836
Denver General Diversion	--	378,860	748,947
To other hospitals (for medically indigent)	--	339,480	380,217
	$ 75,000	$956,116	$1,600,000

Services:

Diversions from -			
Colorado General	250	303	410
Denver General	--	410	580
Others	--	--	464

Migrant Health Program. The program is a coordinated effort to provide comprehensive health care for migrant and seasonal agricultural workers and their families. Activities began in 1962 when funds became available through the National Migrant Health Act. The program provides health screening and medical, dental, and nursing care for migrant farm workers and their families.

Funding:

	FY 1978-79	FY 1979-80	FY 1980-81
General Fund	$ 10,000	$ 10,000	$ 10,000
Federal Funds	635,057	599,015	585,493

Service Area: High Migrant Impact Area, as defined in federal regulations.

Sewer Construction Grants Program. This program is established by the Water Quality Control Act to assist local units of government of 5,000 population or less by providing funds up to 80 percent of the total project cost for sewer construction projects. The program is administered by the Health Department, but initial assessments and commitment of funds is performed by the Division of Local Government.

Funding:

	FY 1978-79	FY 1979-80	FY 1980-81
Capital Construction Fund	$1,000,000	$2,000,000	$2,000,000

Service Area: Statewide

Department of Local Affairs

Planning and engineering for sewage collection and treatment. The Division of Local Government provides funds to municipalities of 5,000 population or less which can demonstrate a need for these funds, and whose sewage treatment facilities do not meet Department of Health standards. These funds are used to conduct planning and engineering studies preliminary to a sewer construction project, and the studies are utilized in applying for state or federal funding for the project.

Funding:

	FY 1978-79	FY 1979-80	FY 1980-81
General Fund	$ 150,000	$ 100,000	$ 120,000

Service Area: Statewide

Emergency water and sewer funds. The Division of Local Government also assists local units of government in alleviating emergency situations relating to water and sewer system failures. The criteria for access to these funds is that the local municipality is experiencing a major health hazard due to a sudden, unplanned circumstance, and that they have no funds available for necessary repair work. As a result of these criteria, funds are most often granted to rural areas of 5,000 population or less.

Funding:

	FY 1978-79	FY 1979-80	FY 1980-81
General Fund	$ 200,000	$ 500,000	$ 500,000

Division of Energy and Mineral Impact. This division of the Department of Local Affairs is responsible for administering the Local Government Severance Tax Fund, the Local Government Mineral Lease Fund, and the Oil Shale Trust Fund, all of which are designed to provide economic assistance to communities which are faced with the need for additional municipal services as a result of the energy-related impact on Colorado's Western Slope. The numerous grants made to date include funding of medical facilities, mental health programs, and water and sewer projects.

Colorado State University

Health education. The cooperative extension service conducts health education and health promotion programs in local communities. Program activities are conducted through the 57 county and area offices of the extension service. One particular project, the Workplace Health Program which is funded by a grant from the Kellogg Foundation, is operated in conjunction with the Rural Environmental Health Institute at CSU to provide health information to agricultural communities and small rural businesses.

Regular program funding in health education is in conjunction with the on-going extension service program at CSU.

Office of Lieutenant Governor

State Office of Rural Health. The purpose of the office is to serve as an advocate for the rural sector, serving both the providers and consumers of health and medical services. It serves as a clearing center and information center for those concerned with rural health. Specific programs sponsored by the office include: a manpower and jobs matching consortium; The Rural Health Factor (funded by an ACTION grant until 1984), a newspaper designed as a communications link between rural areas and urban resources; and the sponsorship of the Colorado Rural Health Conference, a statewide forum on rural health issues.

Colorado Rural Health Recruitment and Manpower Consortium. The consortium seeks and places health professionals in rural areas. The program represents 30 organizations active in the rural health field, and its activities are funded by community support, the Office of Rural Health, The Colorado Medical Society, and the Academy of Physician Assistants.

FUNDING

Family Practice Training Programs

FY 1979-80

	# residents	Total Cost	General Fund	UCHSC	Hospital	Federal Grants	Patient Revenue
A.F. Williams	24	$1,545,586	$ 566,262	$ 379,526	$ 15,000	$ 348,574	$ 236,224
Pueblo	18	873,409	194,487	69,873	150,000	178,922	350,000
St. Joseph	10	514,506	8,052	--	425,179	-0-	81,275
Mercy	28	1,101,639	24,278	--	636,324	228,150	212,713
Greeley	12	720,721	79,161	--	158,755	196,313	286,492
Ft. Collins	12	557,649	47,916	--	122,745	181,488	205,500
Grand Junction	12	518,256	39,087	--	118,744	171,790	188,635

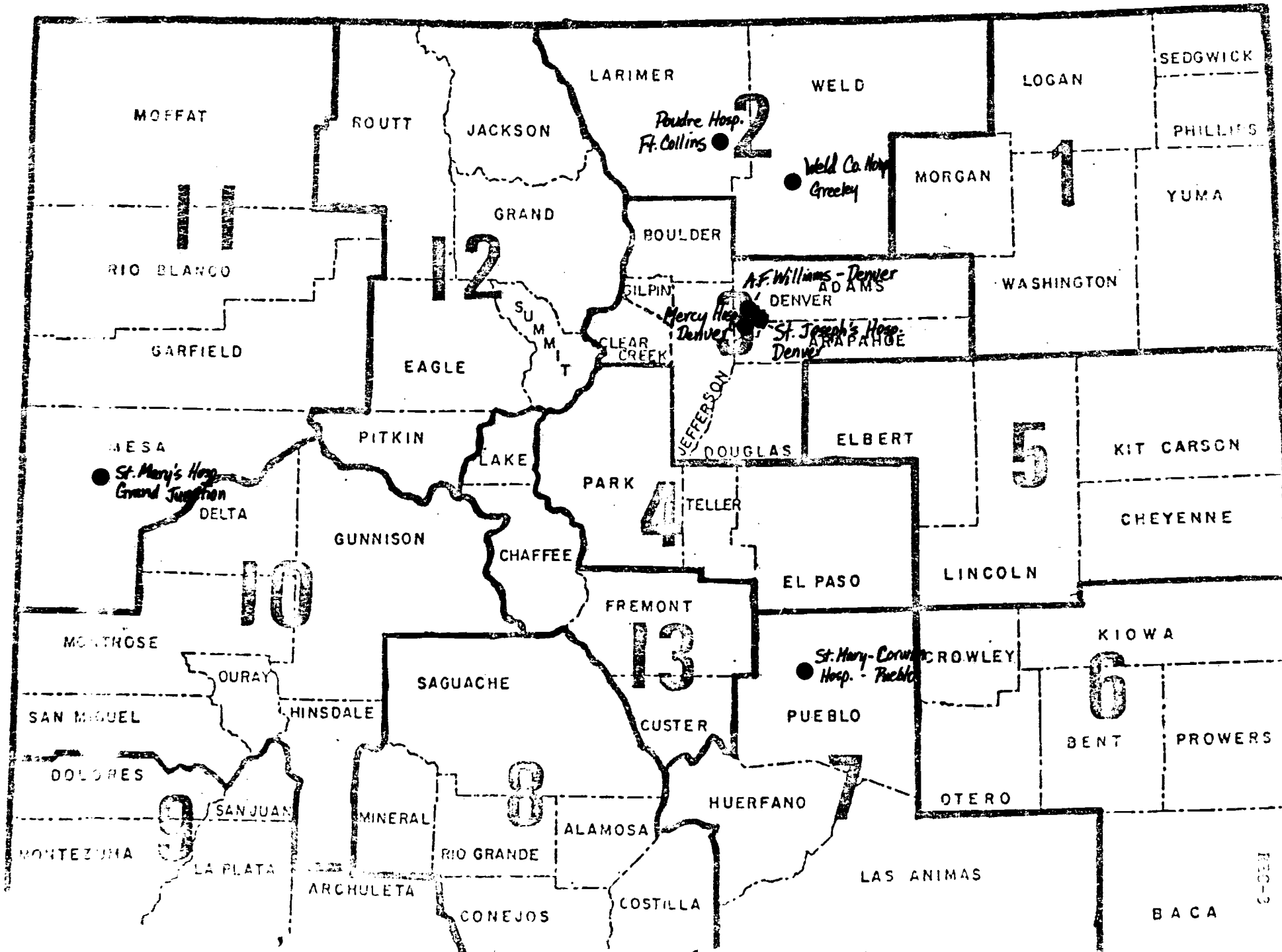
1980-81

A.F. Williams	22	1,700,145*	445,572			200,000*	
Pueblo	18	978,218*	475,704			-0- *	
St. Joseph	11	596,247*	13,801			100,000*	
Mercy	24	1,321,967*	122,410			-0- *	
Greeley	12	807,208*	187,717			-0- *	
Ft. Collins	12	624,567*	93,556			100,000*	
Grand Junction	12	580,447*	127,213			100,000*	

* estimates

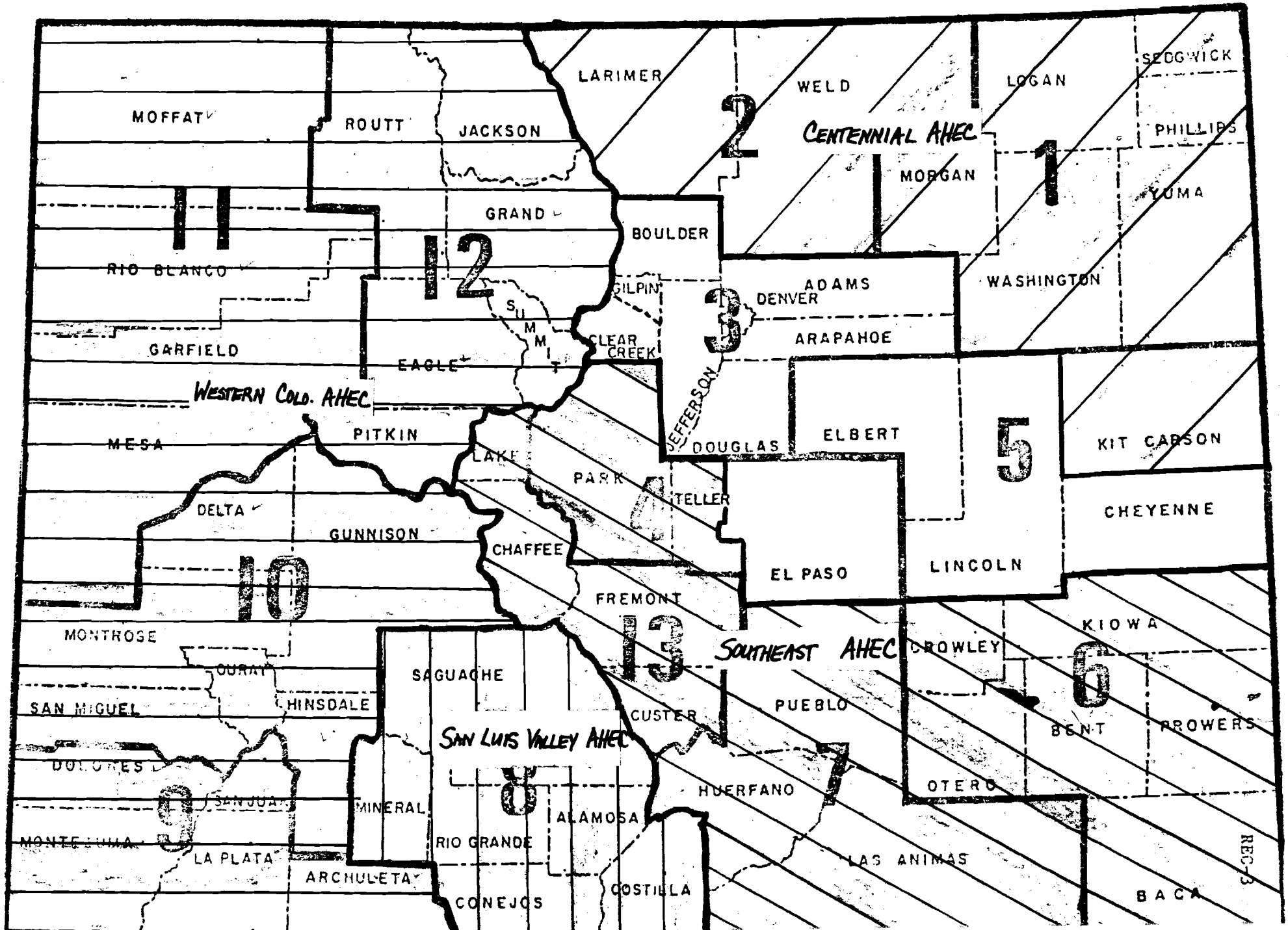
Family Practice Programs

Map # 1



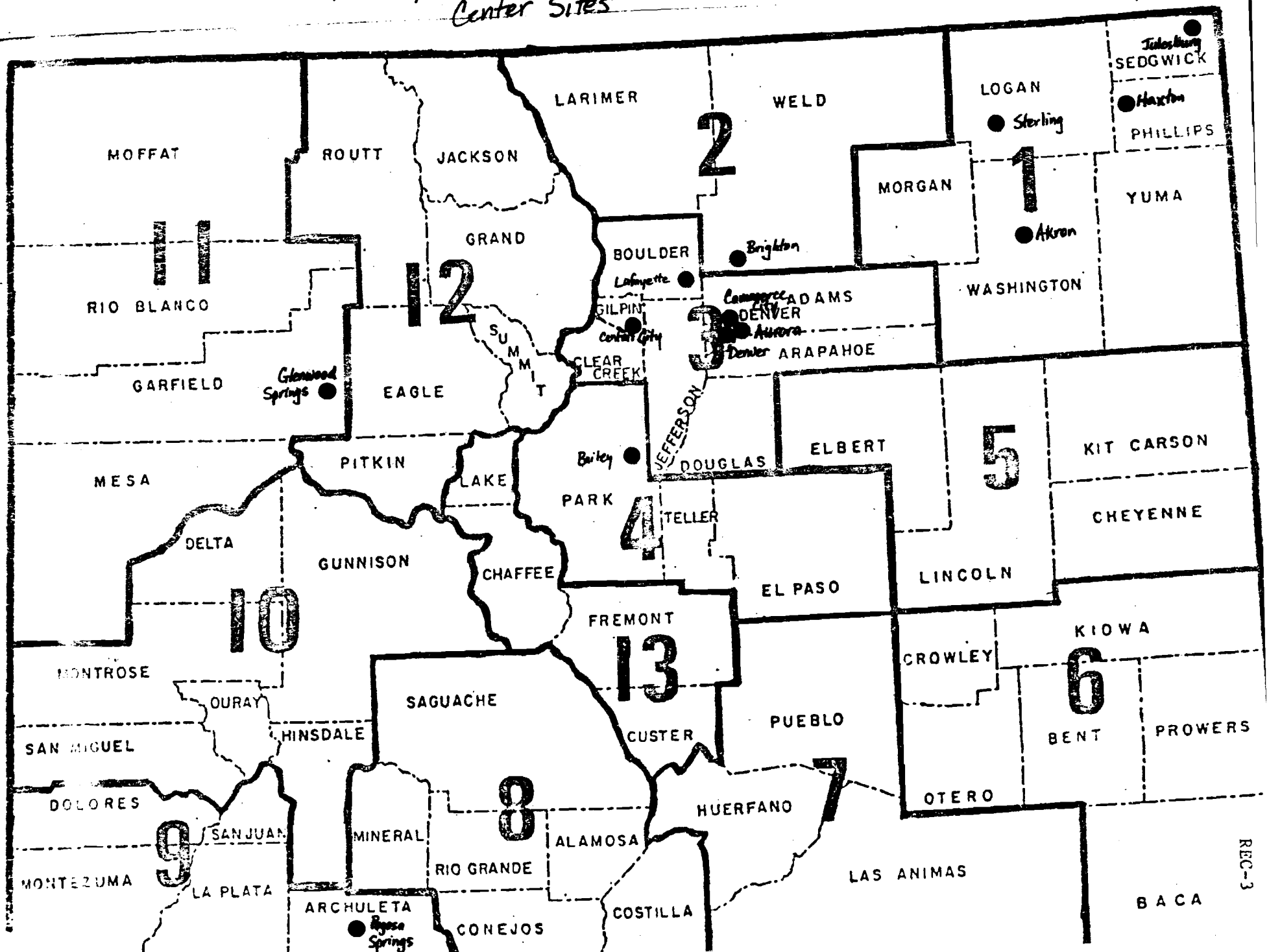
SEARCH Program
Area Health Education Centers

Map # 2



Mountain/Plains Outreach Program (M/POP)
Center Sites

Map # 3



REC-3

Map # 4

LOCAL PUBLIC HEALTH SERVICES

(1979)