Report to the Colorado General Assembly:

RECOMMENDATIONS FOR 1988

LONG-TERM HEALTH CARE NEEDS

COLORADO LEGISLATIVE COUNCIL

RESEARCH PUBLICATION NO. 315
December, 1987

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To Members of the Fifty-sixth Colorado General Assembly:

Submitted herewith is the final report of the Committee on Long-Term Health Care Needs. The committee was appointed by the Legislative Council pursuant to House Joint Resolution No. 1032, 1987 session.

At its meeting on November 18, the Legislative Council reviewed this report. A motion to forward the report and recommendations of the Committee on Long Term Health Care Needs to the Fifty-sixth General Assembly was approved.

Respectfully submitted,

/s/ Senator Ted Strickland
Chairman, Colorado Legislative Council

TS/pn

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COMMITTEE ON LONG-TERM HEALTH CARE NEEDS

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* Resigned from the House of Representatives and sworn in as a Senator on November 10, 1987.

SUMMARY OF RECOMMENDATIONS

The Committee on Long-Term Health Care Needs was directed by the Legislative Council, pursuant to House Joint Resolution 1032, 1987 session, to conduct a study in cooperation with the Department of Social Services to examine the long-term health care needs of the elderly citizens of Colorado. The study charge was to include the examination of various strategies for the delivery and financing of long-term health care, including but not limited to the following:

(a) an examination of changes in the structure of the elderly population resulting from a decline in the mortality rate;

(b) a review of funding for home health care and the provision of follow-up nursing home care;

(c) an evaluation of standards and regulations for skilled and intermediate nursing care facilities with emphasis on the development of specialized services and care units for persons with Alzheimer's Disease and other related dementias;

(d) consideration of requesting the President and the Congress to allow a federal income tax deduction for the total premiums paid by a taxpayer for long-term care insurance; and

(e) an examination of the state's long-term care financing priorities, including study of the current Medicaid reimbursement strategy.

Committee Meetings and Testimony

In an effort to meet the study requirements, the committee held eight full-day meetings, received testimony from over 60 witnesses representing over 40 organizations or interests, and consulted with nationally recognized experts in the long-term health care field. The first five meetings were devoted to testimony concerning long-term health care needs, demographics, special populations, delivery of services, financing, and other states' systems and activity in the area. One-half day was spent in small groups touring various representative long-term health care facilities. Some committee members and staff also participated in internships with physicians working in the long-term health care area. Recommendations for changes and solutions to problems were presented.

Initially, there were 35 recommendations for legislation. The last three meetings were used to examine the proposals for legislation. After testimony and committee discussion on the proposals, the committee referred about half of the proposals to the Legislative Council staff for additional research; other recommendations were either drafted into proposed bills, or not acted upon. Specific testimony was then taken on the remaining proposals and research was reviewed. In the last meetings, the committee reduced the number of recommended proposals to 19 bills and two resolutions. These bills and resolutions are summarized in this report under the following headings.

A. Long-Term Health Care System Development

B. Quality Care

C. Financing Long-Term Health Care

D. Alzheimer's Disease and Special Populations

E. Legal Issues Affecting Long-Term Health Care Delivery

A. Long-Term Health Care System Development

Concerning the Creation of a Task Force on Long-Term Health Care -- Bill 1

Bill 1 establishes a task force to study policies and programs for long-term health care in Colorado. The study charge includes the development of a unified statewide long-term health care plan and budget and implementation of administrative and management procedures designed to build a cost-effective and coordinated long-term health care system. Colorado currently has services for long-term health care in three executive departments and many programs are not coordinated. The need for coordination in future planning and current activities is great and could possibly reduce departmental administrative costs.

The bill sets the membership of the task force at 25, including six legislators; six representatives of hospitals, nursing homes, home and community based caregivers, dieticians, and physicians; six individuals representing special needs of long-term health care patients including stroke, Alzheimer's Disease, chronically mentally ill, disabled infants, AIDS, and spinal cord and head injuries; two persons from elderly advocate organizations; one representative of each of the Departments of Social Services, Health, and Institutions; a representative of the University of Colorado Health Sciences Center; and the state nursing home ombudsman. One of the legislators is to be appointed chairman. The bill authorizes the task force to accept grants or donations to pay for the necessary research and support staff.

Concerning the Implementation of a Continuum of Care for Elderly and Disabled Persons Who Require Long-Term Care, and Making An Appropriation in Connection Therewith -- Bill 2

Services for categorically needy. Bill 2 authorizes the implementation of the services listed below for the categorically needy under the state Medicaid law, if the director of the Department of Social Services determines that the services are cost-effective. The committee was convinced by the testimony that offering these services at home would be more cost-effective than providing these services in hospitals. Those services authorized in the bill are:

-- private duty nursing;
-- ventilator services;
-- hospice benefit services;
-- case management services; and
-- personal care.

If the personal care option is implemented, the bill enables the Department of Social Services to provide Medicaid personal care services to persons who are receiving or are eligible to receive a home care allowance. The Medicaid personal care option may only be extended to those individuals if it is determined to be cost-effective, as compared with other options, by the executive director of the Department of Social Services.

Client needs assessment. The bill also requires that the Department of Social Services develop a client needs assessment program. The client needs assessment provision requires that nursing homes refer all new applicants to a voluntary pre-admission needs assessment review of the client's care needs and payment options and means. The voluntary review would inform the client of their health care needs and appropriate alternatives to nursing home care, should the client not require that skilled of a level of care. The department would be able to assess a fee for the pre-admission needs assessment.

If a nursing home does not refer an applicant for the pre-admission review, and the client is admitted to the nursing home and subsequently qualifies for state assistance, the department may deny payment to the home for up to six months. However, the nursing home is not allowed to deny appropriate care or seek to recover from the patient, his family, or his estate the costs for that care in these instances.

Long-term health care access. The bill also establishes a pilot project on long-term health care access. The pilot project will consider the coordination of care services at the community level and how accessible they are to all the persons in need of long-term health care. This pilot project will assist the department in assessing the availability of services and health care options in Colorado.

Appropriation. An amount of $809,871 and 1.25 FTE is requested for the Department of Social Services for the implementation of private duty nursing services and services to the ventilator dependent. Under the bill, the sum of $24,739 and 2 FTE is allocated to the department for the implementation of personal care services; $20,840 and 2 FTE is appropriated for the pre-admission needs assessment review portion of the bill.

Concerning the Study of Case Management Services, and Providing for a Legislative-Interagency Task Force on Case Management and Pilot Project for an Independent Case Management System, and Making an Appropriation Therewith -- Bill 3

This bill creates a second task force to work with state agencies and with advocates of an independent case management system to study the delivery, administration, and financing implications of

independent case management services for all disabled persons. This task force has the specific charge to study independent case management. The task force would also study the feasibility and cost-effectiveness of an independent case management system for clients who currently receive services from the Division of Mental Health of the Department of Institutions. The concept of case management was reported to be a cost-effective way to provide a single point of entry to assess clients' needs, determine their strengths and weaknesses, and then provide a coordinated plan for services with information provided from the client, family members, and an inter-disciplinary team of advisors. The case manager is to monitor the services delivered.

The Department of Institutions is required to administer a pilot case management project for chronically mentally ill persons and disturbed youth located in a rural area of the state. The pilot project will institute a system of case managers independent from any state program or state agency. The issue of case management for the chronically mentally ill was brought to the committee by persons and organizations concerned about the manner in which the chronically mentally ill have been served since deinstitutionalization. Testimony indicated that the mentally ill have not been adequately served through the community mental health centers. An independent case management system might better ensure that the specific needs of these clients are met through the system.

The bill appropriates $36,000 to the Department of Institutions for implementation of the pilot project and the study of case management. The department is authorized to seek grants or other private sources to help pay for the pilot project.

B. Quality Care

Concerning Persons Employed as Nurses' Aides By Certain Skilled and Intermediate Nursing Facilities -- Bill 4

The bill establishes minimum training requirements (80 hours or whatever minimum is established by the federal government) for nurses' aides in skilled or intermediate nursing facilities. It also contains a grandfather clause exempting current nurses' aides and prohibits contract service nurses' aide employees from working without certification. The State Board for Community Colleges and Occupational Education is designated as the certificating agency and the agency to approve the instructional program. The required instruction, however, may be provided by public or private schools, health care facilities, or other entities.

Certain protections for potential nurses' aides are included in the bill:

-- a prohibition against salary reductions to pay for necessary course work;

-- a prohibition against requiring a nurses' aide to attend training during non-work time;

-- when written language is a barrier, training examinations are required to be conducted orally; and

-- there is a six-month time period during which certification must occur.

The majority of all contact with long-term health care patients occurs with the nurses' aide and the turnover of nurses' aides is high. For these reasons, the need to educate the aides about their work and provide some minimum training level was identified as a need in the area of long-term health care. This bill attempts to provide training requirements without placing undue burden on the nurses' aides or the facility.

Concerning an Extension of the Hours During Which the Department of Health May Inspect Health Care Facilities -- Bill 5

The Department of Health would be allowed to conduct inspections of health care facilities seven days a week and 24 hours a day under this bill. By eliminating time restraints, the department would be better able to perform thorough and unannounced inspections. Thus, the extended hours of inspection will enhance the department's ability to evaluate and maintain the quality of care in nursing facilities.

Concerning the Establishment of a Quality Care Incentive Allowance for Long-Term Health Care Providers, and Making An Appropriation Therefor -- Bill 6

Bill 6 establishes incentives to reward long-term health care providers that furnish a high level of care and to provide the public with information about the quality of care available at long-term health care facilities. A committee is created to develop a three-star rating system of nursing care facilities that receive Medicaid funding. To avoid the need for additional review of the nursing care facilities, the recertification system used to certify care facilities for Medicaid funding will also be used for determining incentives, but only categories dealing with direct patient care are considered. The General Assembly is to make an undetermined appropriation to the "quality care incentive allowance fund."

Concerning Incentive Payments to Nursing Facilities Which Successfully Discharge Medicaid Patients, and Making an Appropriation in Connection Therewith -- Bill 7

Under Bill 7, the Department of Social Services is directed to establish a one-year pilot program to provide incentives to nursing facilities that successfully discharge Medicaid patients. The bill provides 15 days of reimbursement, based on a reasonable cost per day of nursing care, be paid to a facility that rehabilitates and discharges a Medicaid patient. To receive the funds, the patient may not be readmitted to a nursing facility or a higher level of care for a related disorder for at least 60 days. The program is intended to reduce the amount of money the state pays for the Medicaid program by lowering the number of Medicaid patients or possibly reducing the level of care necessary for that patient. Improved rehabilitation services in long-term health care facilities is another expected result. The bill appropriates $10,000 for the implementation of the pilot program.

Concerning Methods to Encourage the Development of Child Care Centers in Nursing Homes -- Bill 8

The purpose of Bill 8 is to encourage the development of child care centers in nursing homes and to promote the concept of intergenerational contact between children and the elderly. By lessening the administrative burden of complying with licensure rules and regulations for child care centers and nursing homes, as well as providing some "start up" funds for nursing homes, the committee believed that intergenerational programs would be promoted. Child/elder programs have been proven effective in enhancing the experience of the elderly in nursing homes and providing children with valuable contact with elderly persons. Research shows that child/elder programs have a positive effect on the responsiveness and social behavior of the elderly.

Bill 8 has two distinct components. The first part establishes a matching grant program to provide seed funds for nursing homes interested in starting child care centers. The bill specifies that the funds will be distributed on a first come, first served basis to nursing homes approved by the Department of Health and which have obtained matching funds. The second part of the bill requires that the Departments of Health and Social Services work together with the nursing home industry, child care operators, and experts on intergeneration programs of this type. They are directed to study existing statutes and regulations and to report to the General Assembly concerning statutory changes to allow for a waiver of nursing home licensure regulations and a separate licensure program for the operation of a child care center in a nursing home facility. There is an appropriation of $100,000 to the Department of Health for the grant program and implementation of the act.

Concerning the Inspection of X-ray Producing Machines, and Making An Appropriation in Connection Therewith -- Bill 9

A more consistent program of annual inspections of X-ray machines by qualified, independent inspectors approved by the Department of Health is authorized in Bill 9. The bill is intended to lessen the department's current burden to inspect machines throughout the state, lessen amount of time it takes to inspect machines, and reduce the department's costs associated with state travel for the inspection of X-ray machines.

The State Board of Health is required to adopt rules and regulations establishing minimum specifications for all X-ray machines, set qualifications of persons authorized to inspect the machines, and establish procedures for an annual inspection of all types of X-ray machines. The annual inspection will be a uniform requirement; currently, machines in hospitals and some other locations are inspected more frequently than other machines.

The bill declares that the inspection of X-ray machines is an issue of statewide concern. By setting statewide standards, the bill disallows other governmental entities from establishing other standards.

A misdemeanor is recommended for knowingly using any machine not certified and disciplinary action is to be taken against any qualified inspector who incorrectly certifies an X-ray machine as meeting the set standards.

The bill also changes the name of the Radioactive Materials Control Fund is changed to the Radiation Control Fund. A fee is authorized for the approval of persons to be inspectors and for a certification or a non-certification sticker to be affixed to the machine after inspection. An undetermined appropriation is made to the department for implementation of the act.

Concerning the Repeal of Provisions Which Prohibit the Direct Access of the Public For Physical Therapists -- Bill 10

Bill 10 allows the public to have direct access to a physical therapist by repealing the statute which prohibits a physical therapist from treating a patient without first obtaining a prescription or referral of a physician, dentist, or podiatrist.

C. Financing Long-Term Health Care

Concerning Eligibility of Married Persons for Medical Assistance -- Bill 11

The committee determined that the problem of spousal impoverishment due to the costs of one spouse's medical care is widespread, and is a problem that needs to be addressed.

This bill provides that only the applicant's share of a married couple's total non-exempt resources and income may be considered in determining eligibility for nursing home care under the medical assistance act (Medicaid). A presumption is established that the applicant has one-half share in the couple's resources. Standards are set for an applicant or spouse to rebut this presumption. The Department of Social Services is given an enforceable right against certain spouses or recipients for the cost of medical assistance furnished to the recipient spouse.

Joint Resolution 1 and Joint Resolution 2

Prior to the enactment of House Bill 1331 (the flat tax bill), 1987 session, amounts received from interest earned on Individual Medical Accounts (IMAs) were deductible from taxpayers' federal adjusted gross income when calculating state income tax. Long-term health care insurance premiums were also deductible prior to passage of House Bill 1331. The committee debated the issue of reintroducing state tax deductions for these two long-term health care savings incentives, but determined not to recommend state tax deductions due to the recent passage of the flat tax bill. Instead, the following two resolutions are recommended.

Joint Resolution 1. As an incentive to encourage individuals to plan for their future and to pay for their own health care needs, Joint Resolution 1 urges the United States Congress to enact legislation providing a federal income tax deduction for money deposited into an Individual Medical Account.

Joint Resolution 2. Joint Resolution 2 urges that the United States Congress enact legislation to provide a federal income tax deduction for individuals for long-term health care insurance premiums. The resolution recommends that long-term health care insurance premiums be included as a medical expense for federal income tax purposes, and that the current 7.5 percent federal threshold for medical expense deductions from adjusted gross income be lowered. The federal income tax deduction would be an incentive for individuals to purchase long-term health care insurance in order to pay for their own health care needs and to possibly reduce future government costs for nursing home or other long-term health care.

D. Alzheimer's Disease and Special Populations

Concerning Disabled Adults in Need of Protective Services, and Providing for the Discovery, Investigation, and Treatment Thereof, and Making An Appropriation Therewith -- Bill 12

The availability of protective services that are currently offered to elderly and children is expanded under Bill 12 to include disabled adults between the ages of 18 and 65 years old. Disabled adults are vulnerable to abuse and need protection services from county social service departments. The bill limits the protective services to those services constituting the least restrictive intervention necessary to remedy the situation. It urges persons having reasonable knowledge to believe that a disabled adult is in need of protective services to inform the county department of social services. The county is to assess the need in each reported case; to prepare to plan for protective services; to take action to supply the protection; and to notify licensing authorities of any hospital or care facility of all instances of abuse of a disabled adult occurring at such facility.

There is an undetermined appropriation to the Department of Social Services for implementation of the act.

Concerning the Development of a Specialized Training Program on Dementing Illnesses Including Alzheimer's Disease, and Making an Appropriation in Connection Therewith -- Bill 13

The Department of Social Services is directed under Bill 13 to contract with a provider knowledgeable in the diagnosis, treatment, and care of persons with Alzheimer's and other related illnesses to provide: 1) training to designated personnel; 2) basic information and guidance to families; and 3) training to families enabling them to serve as caregivers, when appropriate. The Department of Social Services is to take applications for training from public and private agencies, with an emphasis on training personnel located in the rural areas of the state.

Because of the nature of Alzheimer's Disease and other dementing illnesses, specialized patient care and knowledge of the disease is important for the caregiver. To implement this act, $12,000 is appropriated to the Department of Social Services.

Concerning the Establishment of an Alzheimer's Disease Respite Care Pilot Program, and Making an Appropriation in Connection Therewith -- Bill 14

Because of the immense stress on the family and other Alzheimer's Disease caregivers, the need for accessible and affordable respite care relief was identified as a priority by the committee. Respite care may extend the length of time that an Alzheimer's patient is able to remain in the home because of the relief it provides to the primary caregiver. The respite relief may enable the caregiver to continue caring for their loved one.

Bill 14 directs the Department of Social Services to establish a pilot program to provide respite care for persons afflicted by Alzheimer's Disease. Projects would be developed to encourage different models of respite care appropriate for metropolitan, suburban, and rural settings. The program would also provide an evaluation component to include:

-- the determination of aspects of successful respite care (case management, time away from home, and informal support) that enables the family to act as a care provider;

-- the identification of what services are appropriate during the different stages of Alzheimer's Disease; and

-- improved data base development.

Grants or donations may be accepted to pay for all or part of the pilot program and an appropriation to the Department of Social Services of up to $200,000 is included in the bill.

Concerning Requirements for Policies of Long-Term Care Insurance -- Bill 15

Alzheimer's Disease may no longer be excluded from long-term health care insurance policies due to lack of previous medical treatment under Bill 15.

The bill states that insurance policies for long-term health care that cover Alzheimer's Disease, senile dementia, other organic brain syndromes, or other types of senility diseases shall not require prior hospitalization or nursing home institutionalization of the insured in order to receive coverage for home health care. Many Alzheimer's patients become forgetful, disoriented, confused, and are in need of home health care, but do not require hospitalization or the skilled or intermediate care provided at a nursing home.

E. Legal Issues Affecting Long-Term Health Care Delivery

Concerning the Rights of Persons to Reject Life-Sustaining Nourishment -- Bill 16

Bill 16 expands an individual's "living will" to include the withdrawal of life sustaining nourishment in certain instances. The bill amends the "Colorado Medical Treatment Decision Act" to allow an individual to designate in his "living will" that nourishment provided through medical procedure or intervention be withdrawn after a period of 30 or more days, if nourishment is the only life-sustaining procedure being used. Because many elderly persons are in situations where life-sustaining nourishment may be their only life source for months or years, allowing them to choose to continue or to discontinue the life-sustaining nourishment was supported by the committee.

Concerning the Statutes of Limitations for the Commencement of Civil Actions in Colorado and in Connection Therewith Reinstating the Statute of Repose for Actions Involving Health Care and Amending the Definition of Persons Under a Disability and the Provisions Relating to the Accrual of Certain Causes of Action -- Bill 17

Bill 17 attempts to control malpractice litigation costs that lead to increases in malpractice insurance rates. High rates impact health care delivery, including long-term health care, especially in rural areas. The bill reinstates former statutory provisions of limitations concerning actions against health care providers. The provisions were not included in the omnibus statute of limitations revision bill of the 1986 session.

The bill provides that actions against health care providers may not be instituted more than three years after the injury except in the case of:

-- knowing concealment and leaving an unauthorized foreign object in a patient's body, for which there is no limitation; and

-- actions brought by or on behalf of a minor under six years old on the date of the occurrence, which may be instituted up to two years after the minor has reached six years of age.

The bill specifies that a cause of action accrues for an injury on the date the injury is discovered, or should have been discovered, rather than on the date both the injury and its cause are known or should have been known.

Concerning Periodic Payments of Tort Judgments in Civil Actions Against Health Care Providers and Health Care Institutions -- Bill 18

This bill also attempts to control malpractice litigation costs that impact on health care delivery including long-term health care. Judgments concerning future damages in civil actions (exceeding $100,000) brought against any health care provider or health care institution are to be paid by periodic payments rather than as a lump sum payment. Monetary damages awarded for loss of future earnings will not be reduced or terminated by the death of the judgment creditor. The bill structures payments over a long period of time to assure a yearly payment which could be used for health care costs.

Concerning Protections For Quality Management Functions of Health Care Facilities -- Bill 19

Bill 19 declares that quality management systems, used to improve patient and resident care, are essential to the operation of licensed nursing homes and hospitals. The quality of health care can be enhanced through the thorough evaluation of care and services rendered by health care facilities.

In order to provide more complete evaluations of the facilities, the committee determined that confidentiality for evaluation information and qualified immunity for persons providing reports or participating in quality management functions is necessary. An exception from the confidentiality provisions is provided for a regulatory agency authorized by law to make inspections or investigations.

BACKGROUND REPORT

Introduction

The Committee on Long-Term Health Care Needs was charged with a broad study of the complex area of long-term health care policy, delivery, and financing. In conducting this study, the committee identified issues of concern to the entire population in need of long-term health care, but did not limit its study only to the long-term health care needs of the elderly. Consideration was given to long-term health care, those services designated to provide diagnostic, preventative, therapeutic, rehabilitative, supportive and maintenance services for individuals with chronic mental or physical conditions in hospitals, nursing homes or other alternative care settings. By adopting this broad perspective of long-term health care, the committee was able to take a more comprehensive view of the state's long-term health care population, fiscal role, and delivery system.

The committee approached the study charge by gathering information about the number of people in Colorado requiring, or at risk of requiring, long-term health care. After examination of the figures and special populations of long-term health care clients, current state expenditures for long-term health care were analyzed to identify cost containment options, financing priorities, and delivery system standards.

Most of the testimony and committee discussion focused on the need for long-range planning of a comprehensive long-term health care system for Colorado. The committee reviewed a comprehensive package of recommendations from the Department of Social Services for a "continuum of care", but determined that not all of the department's recommendations should be approved for 1988 because of the complexity of many of the issues. One of the committee's major recommendations is that a task force be created to take a long-range look at the long-term health care continuum in a way that the eight interim committee meetings did not allow.

This report describes the committee's findings in the areas of: 1) demographic trends; 2) service delivery systems; 3) financing; and 4) Alzheimer's Disease and special populations.

Demographic Trends

National Demographics

During recent years, various government agencies and private research organizations have made dramatic projections about the future life expectancy and size of the older population in America. These projections suggest significant future increases in life expectancy and a large increase in the number of elderly as a percentage of the population. In the census of 1980, there were 25.9 million Americans ages 65 and over -- 11.1 percent of the population. By the year 2040, when all remaining "baby boomers" (those born in the 19-year period from 1946 to 1964) will be in their older years, it is projected that there will be 67.3 million people ages 65 and older -- 20.5 percent of the population.

Projections for the total population from 1980 to 2000 show an increase of 18 percent, while the group aged 65 and over is expected to increase 37 percent. By the year 2000, 13.1 percent of Americans (35 million people) will be over 65 years of age and 6.5 percent (17 million people) will be over 75 years of age. By the turn of the century, the 75-85 age group is expected to increase from 7.7 to 12.2 million, while the population over 85 will more than double. The over-85 population is projected to increase three to four times faster than the population at large during the next two decades.

Colorado Demographics

In 1987, there were approximately 302,000 persons in Colorado over the age of 65, or 11.1 percent of the total state population. This total represents a 21.6 percent increase in this population since 1980. It has been estimated that at least 12 percent of Colorado's over 65 population is below the poverty level.

Based on projections of the demographics section of the Colorado Department of Local Government, the elderly population in Colorado will continue to increase relative to the state's total population in greater proportions annually. For example, from 1987 to 1990 the state's elderly population is predicted to increase by 8.4 percent. From 1990 to the year 2000, the elderly population over 65 is anticipated to increase by 23.3 percent. In population terms, that percentage equals an over 65 years of age population of 404,800 persons in the year 2000.

Mortality

Decreasing mortality rates have had and will continue to have a significant impact on the need for long-term care. Based on mortality experience in 1900, a man or women born in that year could expect to live an average of 47.3 years; by 1982, life expectancy reached 74.5 years. From 1940 to 1980, the age-adjusted death rates for the elderly decreased by 38 percent. About half of the overall decline in mortality among the elderly during this period resulted from the decline in heart disease mortality and another quarter is associated with the fall in the death rate for stroke survivors. Contributing factors include improved medical services, greater availability of coronary care units, advanced surgical and medical treatment of heart disease, improved control of blood pressure, decreased smoking, increased exercise, and healthier life styles in general.

Use of Health Care Services

The incidence of chronic illness increases with age and becomes a major cause of disability requiring medical care. Since the need for health care increases sharply with age, the very old (85 and over) have more need for medical assistance than the younger-old (65-85 years old). Older persons with chronic and disabling conditions are high users of medical resources. Studies show that elderly people make more frequent visits to physicians, are hospitalized more frequently, and stay in the hospital longer than younger people.

The rate of long-term care utilization also increases dramatically with age. For individuals over 85 years of age, the rate of use is 23 percent of that total population; for the 75 to 85 years of age, the rate is six percent; for the 65 to 74 age group, the utilization rate is two percent. About five percent of all elderly are in nursing homes compared with about 23 percent of the very old. Other chronically ill elderly persons are in psychiatric or other chronic disease hospitals, veteran's administration hospitals, and other long-term care facilities.

The impact of the aging of the population in the United States is projected to increase the number of days of hospital care required by 28 percent. The total number of physician visits is projected to increase 19 percent, and the number of nursing home residents is projected to increase 69 percent. There are regional variations to these projections. In the South and West, where the elderly will increase 60 percent, it is projected that the number of nursing homes will need to more than double to meet the needs of the projected elderly population.

Availability of Nursing Home Care and Number of Patients by Payment Source in Colorado

Nursing home occupancy. The following tables provide the number of licensed nursing care beds in Colorado (for the period October 1, 1986 through September 30, 1987) and lists patients by payment source and type of care. The total number of beds includes the 24 non-medicaid facilities in the state. It should be noted that nursing home beds licensed for skilled care may be occupied by patients needing intermediate care and that the number of empty beds was based on a one-day count completed on the day of each facility's inspection.

Table I

Nursing Home Capacity and Occupancy in Colorado for 1987

Number of Beds -- All Categories by Level of Care		
Skilled Care	12,938	
Intermediate Care	5,813	
Total Number of Beds		18,751
Total Number of Empty Beds in State		2,514
Approximate Occupancy Rate		86.6%

SOURCE: Department of Social Services

Table II

Number of Patients by Payment Source -- 1987

Title 18 -- Medicare Skilled Care	319	
Title 19 -- Medicaid Skilled Care	3,828	
Intermediate Care	6,102	
Private Pay -- Skilled Care	2,797	
Intermediate Care	3,191	
Total Number of Patients -- All Categories		16,237

Committee recommendations. Using projections from the tables presented concerning the future increased need for nursing home care, the committee recognized the importance of increased access and alternatives for long-term health care delivery. It was recommended that the development of alternative service systems from the private sector should be emphasized to reduce the dependency on government sponsored long-term health care programs.

Service Delivery Systems

Informal Support Systems

Families have provided crucial and irreplaceable support for many older persons. For example, it is estimated that family members provide about 60 to 80 percent of the care received by the disabled and elderly. Reports show that many families today are under considerable stress as they seek to remain intact and attempt to cope with the problems associated with caring for an elderly person.

The generation of "baby boomers" may face a different situation than existed in the past or exists today. First, they are having smaller families or not having children at all. The support from children in future years will be limited by the number of children they have. Second, the high divorce and remarriage rates, and the often low levels of child support payments, may contribute toward less financial assistance between the generations. Third, since a longer life expectancy of "baby boomers" is anticipated, it will become more difficult for the children of elderly parents to care for them. It may be a different situation for 45-year olds to care for their 65-year old parents than for 65-year olds to care for their parents.

Services to assist caregivers. The availability of services to assist families in their care giving role is also vitally important. Respite care, home care, personal care services, preventive outpatient care, dental care, and adult day care are among the services required to provide assistance to families who are under stress in caring for the elderly. Middle-income elders and their families and relatives may find it difficult to find available services such as respite care and adult day care, even when they can afford to pay some portion of these services.

Committee recommendations. Due to the immense stress on family and other Alzheimer's Disease caregivers, the need for accessible and affordable respite care relief was identified as a priority by the committee. The committee recommends Bill 14 which establishes a pilot program to provide respite care for persons caring for others that are afflicted by Alzheimer's Disease.

Alternative Service Systems

Because of the decline in birthrates after 1964, there is concern as to whether the future working age population can produce enough to support the projected increased elderly population. There have been changes in Medicare and Social Security that make it difficult for elderly in need of long-term care to receive state assistance. Social Security has lowered the age of entitlement and further cuts in cost of living adjustments are expected. This lesser support may be exacerbated by the increased needs of the "baby boomers" who are likely to spend more time in old age, with increased need for assistance and support.

With government programs under increasing pressure, there has been more attention focused on the role of alternative government-sponsored programs and the role of the private sector in aiding older people. The committee's findings in regard to several of these alternatives are discussed in the following paragraphs.

Home and community based alternatives. States have attempted to limit the growth of the nursing home population, and thereby reduce or limit the growth of Medicaid expenditures, by establishing home or community based programs. It is contended that many people who do not require institutional care have been placed in nursing homes because Medicaid traditionally did not pay for services that might allow them to be cared for at home or in the community.

In 1981, the Medicaid law was changed to enable states to waive the provisions that limited Medicaid reimbursements for such services. Senate Bill 138 (1982 session) was enacted by the Colorado General Assembly to establish a home and community based program for the elderly in Colorado. A waiver was applied for from the federal government and the program was implemented in 1983. The waiver must be renewed in 1988. This program provides an alternative to nursing home care for the elderly, blind and disabled adults who: 1) are at risk of institutionalization; 2) are Medicaid eligible; and 3) can be served at a cost equal to or less than the average Medicaid cost for an intermediate care nursing facility.

Various evaluations and studies have examined the comparative costs of serving Medicaid long-term care eligible clients in the home and community based program versus the nursing home care alternative. A 1984 University of Colorado Health Sciences Center study found that the total average daily cost of home and community based clients was $20.48, while the daily cost of nursing home clients was $28.01.

While advocates of these various alternative programs claim they will improve the quality of life for those who otherwise may be placed in nursing homes, the federal Health Care Financing Administration (HCFA) says that it may be too soon to assess whether they will save money. Indeed, the study in Colorado cautioned that it may be too

soon to assess the long-range impact of the program on nursing home utilization and the state Medicaid budget.

It is estimated that more than 70 percent of those requiring long-term care are now receiving it outside of nursing homes. The HCFA has expressed concerns that these alternative service programs will serve many people who previously would have been taken care of at home without public assistance, thereby increasing the Medicaid budget. Other studies have indicated that these services have not reduced nursing home or hospital use or total service costs. In 1985, the federal government issued a new set of regulations to subject waiver programs to more scrutiny and cost restraints.

Committee recommendations. Numerous studies on home and community based services show a strong preference among the elderly for such services over nursing home care and that in many instances these alternative care systems can save state dollars. One of the committee recommendations is for a voluntary pre-admission screening program for patients entering nursing homes (Bill 2). The preadmission screening program, currently used in 21 states, will enable patients to learn about their health care needs through the evaluation. When appropriate, alternatives to nursing homes that might better suit the needs of the client will be presented.

The future development of the long-term health care system in Colorado is addressed by recommended legislation to: 1) establish a task force to consider policy and program issues of long-term health care (Bill 1); 2) implement services for the categorically needy, including services to allow the ventilator dependent to be served in the home (Bill 2); and 3) create a case management study and case management pilot project for chronically mentally ill and disturbed youth, particularly in rural areas (Bill 3). These recommendations are designed to better utilize the long-term care dollars spent by the state by serving clients in a less restrictive setting while still providing the quality of care necessary. The Department of Social Services projects that the client needs assessment program, and the provision of services to the categorically needy in the community or at home, will result in a substantial cost savings of over $1 million in general fund appropriations.

Quality of Care

One of the long-term health care issues of great concern involves the quality of care. The committee found that, despite thorough state regulation of health care facilities, several areas can be addressed to assure safety and increase the quality of life for individuals requiring long-term health care.

Committee recommendations. A need was identified to educate nurses' aides and to require a minimum level of training. The majority of all care to long-term health care patients is provided by nurses' aides who are the least educated and have the highest turnover of employees in the health care professions. Therefore, a proposal was approved that set minimum training requirements for nurses' aides (Bill 4). A second bill extends the hours of inspection of health care facilities to 24 hours per day to enhance the Department of Health's ability to evaluate and maintain the quality of care in such facilities (Bill 5). Another bill establishes rewards for facilities that provide a high level of care and a means of informing the public of the care available (Bill 6).

To possibly reduce the amount of money the state spends for the Medicaid program and to improve rehabilitation services in long-term care facilities, a bill is recommended to establish a pilot program to provide incentives to nursing facilities that successfully discharge Medicaid patients (Bill 7). The high turnover rates of employees of nursing facilities is addressed by providing an additional benefit for workers and promoting intergenerational contact between children and the elderly. Bill 8 is recommended to encourage the development of child care centers in nursing homes.

Financing Long-Term Health Care

Expenditures for Long-Term Health Care

Nationally, expenditures for nursing homes have increased significantly over the past decade. Nearly half of those costs, more than $14 billion a year, are now borne by the states and the federal government. Very little of the nursing home expenditures are covered by the federal-only Medicare, but almost entirely through Medicaid, a state-federal program. Since 1960, national nursing home expenditures have increased, growing from $480 million in 1960 to $20.7 billion in 1980. For most of that period, Medicaid spending on nursing homes increased over 20 percent per year, more than twice as fast as total state and local spending.

Medicare, on the other hand, provides health insurance coverage to most individuals 65 and over, and to others, but does not cover long-term care services. There are approximately 28 million elderly and three million disabled eligible beneficiaries on Medicare. In 1983, total outlays exceeded $58 billion. Of this total, 69 percent was spent on hospital services and 23 percent on physician services. Less than one percent was spent for nursing home care. Thus, Medicaid has become the primary vehicle for the payment of long-term care services in the form of nursing home expenditures. However, some 80 percent of the elderly receiving Medicare believe it will cover their long-term care needs when it is actually an acute care insurer.

Medicaid. Medicaid now pays for approximately 48 percent of the total amount of all nursing home costs, and those costs account for nearly half of all Medicaid expenditures nationwide. In some states, the percentage is higher but in nearly every state Medicaid is one of the highest line-item expenditures. Medicaid appropriations in Colorado are under fiscal constraints because state fiscal capacity has not kept pace with program growth. Medicaid expenditure increases have been one-third to one-half higher than the growth rate of state revenue.

Colorado expenditures for Medicaid. In Colorado, approximately 50 percent of Medicaid funds are spent on long-term care patients. This expenditure is for 9.2 percent of the Medicaid population.

It is estimated that approximately three percent of the Gross National Product (GNP) is spent on health care services for the elderly. Many of the elderly become poor in old age and thus qualify for Medicaid. With old age, loss of a spouse, growing disability, and incomes eroded by inflation and medical expenses, the elderly often times find themselves "spent down" to a Medicaid-eligible level. Many middle-class people enter nursing homes as private pay patients and, once their savings are depleted, qualify for Medicaid. It is estimated by the U.S. Department of Health and Human Services that approximately one-half of all nursing home residents on Medicaid are newly impoverished people who spent most of their assets and income paying for medical and nursing home care.

Committee recommendations. Bill 11 is designed to protect spouses from impoverishment due to the medical care needed by their family member. The bill establishes that one-half of the married couple's income and assets belong to the husband and the other half to the wife. This allows a couple to "split" their assets when one spouse enters a nursing home. The spouse remaining at home will not have to spend all the couple's assets on nursing home care and may have the financial support necessary to avoid impoverishment.

Changing the Tax System to Allow Deductions for Long-Term Health Care/Introduction and Federal Role in Income Tax

Federal income tax. Under the current federal income tax system, an individual cannot claim a tax deduction when contributing to the cost of health services for a relative who is not a member of his household. Families and individuals may be discouraged from contributing to the cost of caring for a parent or other relative, even if such care would allow the person to remain in his home and avoid going into a nursing home. Whether state and federal tax systems should be changed to encourage people to share in the costs of caring for parents or others by allowing them to claim such expenses as a tax deduction, is a question which requires further examination.

Employer-mandated long-term health insurance coverage. As a method of reducing public expenditures for long-term care services, it has been suggested that the government mandate the inclusion of long-term care services as part of employer-based health insurance coverage to their retired employees. It has also been suggested that the government mandate that certain long-term care benefits should be included as part of their health insurance policy. Such supplemental benefits could be used as the primary payer, possibly allowing reduced governmental expenditures for long-term care services.

Individual medical accounts (IMA). In 1986, the General Assembly enacted House Bill 1102 which provides for the development of IMAs. An IMA allows, and encourages, people to invest money for medical expenses into a specific account that is not drawn on until retirement or upon reaching a certain age. Originally, individual investments were exempt from state income taxes until withdrawn. Currently, however, these accounts are not exempt from state or federal taxes.

Committee recommendation. The "Tax Equity Act of 1987" (House Bill 1331) imposes a flat income tax rate of five percent with the effect of eliminating the state tax deduction for funds deposited in IMAs. However, the committee believes that individuals should be encouraged to actively control their own finances and that incentives should be developed for individuals to plan for their future and to pay for their own health care needs. Therefore, the committee recommends a resolution to the United States Congress urging that a federal income tax deduction be established for money deposited in IMAs.

Private long-term health insurance. It is thought by some that private health insurers should be able to provide certain long-term care benefits, either as part of their health insurance policies which are sold to employers or as a distinct insurance package sold to individuals. Private long-term health care insurance could help curtail the extent to which private pay patients are forced into the Medicaid program and also help individuals plan for their retirement health care needs.

Advantages identified in the development of private long-term care insurance are the following: 1) provides financial support for the purchase of quality care; 2) enhances the opportunity for consumer choice; 3) preserves the dignity of elderly persons by giving them the opportunity to prudently plan for their potential long-term health care needs; 4) reduces federal and state exposure for the costs of future long-term health care services; 5) helps reduce reliance upon public programs as the source of payment for such services; and 6) assures market competition and induces the expansion of diversified service delivery.

Committee recommendation. Along with the IMAs, the state's previous deduction for long-term health care insurance premiums was

eliminated by the flat tax bill of 1987 (House Bill 1331). However, the committee concluded that long-term health care insurance should be promoted in order to encourage individuals to pay for their own health care needs and possibly reduce government costs for nursing home care. The committee recommends a resolution to the United States Congress urging the enactment of a federal tax deduction for long-term health care insurance premiums.

Other alternatives in the private sector. While publicly financed health care alternatives are facing federal and state fiscal restraints, private sector alternatives seem to be attracting increased attention because of the improved economic status of some of the elderly. Recent economic reports show that the median real annual income of the elderly has more than doubled since 1950 to more than $21,420 (before taxes) for families 65 years of age and over. Among the options that could bring more private dollars into long-term care are financing arrangements designed to use wealth that many elderly have invested in their homes. One approach is the "reverse annuity mortgage" in which an individual retains title to a house but draws on the equity for monthly cash. Another approach is "life care communities" where elderly people pay an initial lump sum amount and monthly fees to live in a private community that offers medical, nursing, and social services.

Alzheimer's Disease

The committee recognized that disorders causing dementias constitute a large and growing public health concern and that there have been few, if any, public policy decisions made in the area. The stress dementing illness has on family members and the need for appropriate care options was of particular concern as the committee studied these illnesses. The committee's findings in this area are summarized below.

Alzheimer's Disease -- Background

Definition. Senile Dementia of the Alzheimer's type, or Alzheimer's Disease, is a progressive, irreversible neurological disorder that affects an estimated 1.5 million American adults. According to a newly released study by the Office of Technology Assessment, it is the most common form of dementing illness. The disease can last as long as 15 to 20 years.

The disease was first identified and described by Alois Alzheimer in 1906. The disease affects men and women almost equally and strikes mostly people over 65; however, it can also strike adults in their 40's and 50's. Alzheimer's Disease and other forms of irreversible dementia, which were thought for years to be a natural part of the

aging process, have now been called "the disease of the century" because of the far-reaching physical, emotional, and financial burdens they place on victims of the disease and their families.

Symptoms. Alzheimer's Disease is a dementing illness which involves loss of memory and loss of intellectual abilities, often severe enough to interfere with routine work and social activities. There are four stages of the disease which are often identified in current research:

Stage 1 -- less spontaneity, less energy and initiative, loss of words, slower to learn, slower to react, easily provoked, seeks and prefers the familiar, shuns unfamiliar;

Stage 2 -- often needs more assistance in specialized activities, much slower in speech and understanding, difficulty making decisions, inability to calculate, self-absorbed, insensitive to feelings of others, loses the thread of a story;

Stage 3 -- obviously disabled, markedly changed behavior, unsure of how to act, needs directions repeatedly, failing memory of recent past, astonishingly clear memory of distant past; and

Stage 4 -- needs help with daily tasks of living, apathetic, poor remote or recent memory, incontinent, preservation of phrases and syllables, no recognition of individuals.

Diagnosis. Reports emphasize the importance of accurate diagnosis, as there are as many as 100 treatable conditions with symptoms similar to those of Alzheimer's Disease. At this time, an absolutely positive diagnosis of Alzheimer's Disease comes only from brain-tissue biopsy (a procedure involving some pain and risk of infection; these procedures are rarely if ever done in the United States) or from autopsy. Recommended tests for Alzheimer's Disease include physical, neurological, psychological, and psychiatric examinations and, occasionally, study of the spinal fluid. While these evaluations may provide a diagnosis of Alzheimer's, the only accurate confirmation of the disease is examination of the brain tissue.

Cause(s) and research. The cause of Alzheimer's Disease is not known and is currently being studied extensively. Suspected causes include a slow virus or other infectious agent, environmental toxins such as aluminum, a genetic predisposition, and immunologic changes. Many other factors are also under investigation. Most of the genetic research has focused on narrowing the genetic alphabet to a smaller number of probable connected characters.

Alzheimer's Disease -- Treatment

Although no cure for Alzheimer's Disease is currently available, it is becoming more recognized that good planning, and proper medical and social management, can ease the burden on the patient and family. Also, appropriate medication may lessen agitation, anxiety, and unpredictable behavior, as well as, improve sleeping patterns and treat depression. Physical exercise and social activity are important, as are proper nutrition and health maintenance.

Drug -- THA. A new drug (THA) treatment for Alzheimer's was developed by a California psychiatrist named William K. Summers. In an initial study, published last year in the New England Journal of Medicine, Dr. Summers reported significant cognitive response in 16 of 17 patients taking the drug. The drug appears to slow the process of the disease. Before the drug is available, the Federal Drug Administration will conduct a test on 300 patients. The availability of the drug will depend on the success of the FDA's test.

Other areas for treatment. Alzheimer's Disease patients may be assisted with treatment programs for the following areas.

-- Counseling and psychological support. Because of the tremendous anxiety and depression felt by these patients, supportive counseling and possibly psychotropic medications for anxiety and depression may prove very useful.

-- Behavioral control. The patient may experience irritability, aggressive behavior, outbursts, and possible paranoia. The careful use of medication may help with this behavior, allowing the patient to remain at home for much longer periods of time and co-exist comfortably with their families.

-- Bladder and bowel control;

-- Stability of walking;

-- Sleep disturbance; and

-- Specific memory improvement. A number of medications are being studied to improve Alzheimer's patient's memory. There is great need, however, to further research these areas.

Programs and Services for Alzheimer's Patients

Most programs and services designed for Alzheimer's patients are less than five years old, and the total number of patients receiving

specialized care is small. There is little research on specialized care for Alzheimer's patients, and according to a major report published in April 1987 by the Office of Technology Assessment (OTA), Losing a Million Minds, additional research is urgently needed to assist caregivers, service providers, and policy makers.

Some of the different services which may be tailored to provide specialized Alzheimer's treatment include:

-- companion care, home health care, and visiting nurses;
-- adult day care;
-- respite care;
-- short-term residential care;
-- hospice care; and
-- residential special care.

Residential special care is receiving much attention due partially to the great number of Alzheimer's patients in residential care facilities. Most specialized residential care is provided by the new development of specialized Alzheimer's units in nursing homes. Both for-profit and the non-profit sectors are hiring experts, having conferences and opening "special" units. Others have not segregated the residents, but offer the special programs in regular units.

"Special" units -- costs -- availability. According to the OTA report, it is estimated that fewer than 500 special units are developed or close to completion, although more are planned. This means that, of the 50 to 75 percent of nursing home patients with a dementing illness, only a small portion are in such units.

The consensus among experts in the area is that good care in special units for dementias requires more staffing and better trained staff, and probably more square feet per patient than required by Medicare, Medicaid, or state standards. The cost factors have not been established, but estimates are that special treatment may cost $5 to $10 more per day over other patients.

Families

It is estimated that about two-thirds of all Alzheimer's sufferers are cared for at home, particularly in the beginning of the illness. It is important, therefore, to consider ways to ease the stress and difficulty of caring for an Alzheimer's patient at home. The nature of the disease makes family care more trying. Many patients are up all night, cannot dress, bath or eat alone, and after a time they may need assistance walking. Furthermore, many patients respond to care with anger or resistance and even may accuse a caregiver of stealing from them, or trying to harm them. All these behaviors thereby complicate the tasks of personal care.

Helping families. Respite care has been identified as a key element in helping families and has been proposed as a means of reducing costs by enabling families to continue home care. Respite care is any formal program that cares for the person with dementia on a part-time basis so that the caregiver may remain employed, and take care of personal needs. Respite programs include in-home personal care, adult day care, in-home companion care, short-term nursing home care, and hospital or boarding home care.

Financing Issues

Medicare. Individuals can establish eligibility for Medicare in many ways. Medicare covers acute medical care, not long-term care. Most elderly qualify at age 65 based on their eligibility for social security benefits. By contrast, the major basis of Medicare eligibility for persons with dementia under the age of 65 is fraught with complexities. Persons under age 65 may establish eligibility if they have been entitled to social security or railroad retirement benefits because of disability for at least 24 months.

Medicaid. Eligibility for Medicaid is largely a matter of state government activity. In Colorado, as in many other states, eligibility is linked to the criteria for Supplemental Security Income (SSI). Medicaid is granted to anyone receiving SSI benefits who applies, but the effect is to require most applicants to be impoverished before eligibility may be established. This situation adds to the difficulties of the families of Alzheimer's patients because most private insurance plans do not cover the services required by a person with dementia. People who cannot establish Medicaid eligibility through the SSI eligibility linkage, generally cannot qualify for Medicaid regardless of the extent of their medical bills. This limitation is included in the federal Medicaid statute.

In Colorado, persons with dementia as well as other aged or disabled persons may be eligible for aid through the nursing home cap program designed to assist persons who are not recipients of Aid for Families with Dependent Children (AFDC) or SSI. Under this program, a nursing home patient with a 1986 income under $1,009 could be eligible for coverage of the costs of care while in the home. This program allows states to provide some financial assistance for nursing home care without opening up its Medicaid programs to all disabled or elderly persons with high medical bills.

Extent of Alzheimer's Disease in Colorado

According to the Colorado Department of Health, as of October 1, 1987, a total of approximately 3,687 Alzheimer's patients are being served in Colorado facilities regulated by the department. (There are approximately 19,000 nursing home patients in Colorado.) Not all facilities have provided the department with data on Alzheimer's patients therefore the estimated number is probably lower than the actual number.

This was the first year that the department included a specific question about Alzheimer's on its annual survey. The question was worded by asking health care facilities how many patients appear to have a dementing illness as one of their three major diagnoses. The department's survey also shows that there are thirteen "Alzheimer's Units" in the some 180 licensed nursing homes in Colorado. These "units" provide some type of specialized care for Alzheimer's patients.

Committee Recommendations

Extensive testimony was presented on long-term health care as it relates to special populations and Alzheimer's Disease. The rehabilitative needs of stroke survivors and the value of a stroke prevention program were considered. The committee also studied a proposal for a case management program for the mentally ill, based on the vulnerability of persons in this group in determining which services and funding possibilities available would be appropriate for their needs.

The special needs of spinal cord and head injury patients were discussed as well as problems associated with infants or other heavy care patients requiring long-term care. The need for respite care to relieve family caregivers for Alzheimer's patients, and the need for additional services in rural areas for Alzheimer's Disease patients was also considered.

Bills are recommended to: 1) extend protective services to disabled adults (Bill 12); 2) develop a specialized training program on dementing illnesses including Alzheimer's Disease (Bill 13); 3) establish an Alzheimer's Disease respite care pilot program (Bill 14); 4) attempt to ensure that Alzheimer's Disease would not be excluded from long-term health care insurance policies due to the lack of previous medical treatment (Bill 15); and 5) create a task force on long-term health care with specific responsibility to study ways of treating and financing the needs of patients with Alzheimer's Disease and other special long-term health care needs (Bill 1).

Other Topics Considered

The urgent issue of the rising costs of malpractice insurance was brought to the attention of the committee. Malpractice insurance costs are effecting the access to quality health care, particularly in Colorado's rural areas where many obstetricians and family medicine physicians who deliver babies are reported to be closing their practices.

Although there has been malpractice reform legislation, in the past, the issue was considered of significant concern to warrant committee action. Testimony was taken and proposals were considered that could help to control malpractice litigation costs that lead to increases in malpractice insurance rates and which is impacting health care delivery including long-term health care.

Committee recommendations. Two bills are recommended to help control malpractice litigation costs. The first bill concerns the statute of limitations and provides that actions against health care providers may not be instituted more than three years after the injury except in certain situations. The second bill would require that judgments against any health care provider be paid by periodic payments rather than a lump sum payment (Bills 17 and 18).

Sources

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3. Improving the Quality of Care in Nursing Homes, Institute of Medicine, Washington, DC, 1986.

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6. Long-Term Care Source Book -- Policy, Data, Colorado Department of Social Services, Denver, CO, July 1987.

7. Summaries of Meetings, Task Force on Long-Term Health Care Policies, Health Care Financing Administration, Washington, DC, 1987.

8. Statistical Abstract of the United States, Bureau of the Census, Washington, DC, 1986.

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Bill 1

BY REPRESENTATIVE Allison;
also SENATOR Hopper.
Interim Committee on Long-term Health Care Needs

A BILL FOR AN ACT

CONCERNING THE CREATION OF A TASK FORCE ON LONG-TERM HEALTH CARE.

Bill Summary

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

Establishes a task force to address policy and program issues in long-term health care, including the development of a unified long-term care plan and budget and implementation of administrative and management procedures designed to operate a cost-effective long-term care system. Specifies the issues to be addressed by the task force. Specifies the membership of the task force. Authorizes the acceptance of grants or donations to pay for research and staff support.

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

SECTION 1. Title 26, Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW ARTICLE to read:

ARTICLE 4.6

Task Force on Long-term Health Care

26-4.6-101. Legislative declaration. The general

assembly recognizes the expanding demographics of the elderly and the disabled in Colorado and that it is expected that the number of persons in need of long-term care support will double between the years 1980 and 2000. The general assembly recognizes the fact that long-term care provided in home and community settings is both preferred by clients and is frequently more cost-effective and that there is a need for the development and support of a well-organized, managed, and controlled long-term care system in this state. The general assembly recognizes that the issues concerning long-term care are complex and varied and, therefore, there is a great need to study and research such issues carefully in order to develop rational legislative and executive responses to the growing demand for a comprehensive long-term care system. Therefore, it is the intent of the general assembly that the task force appointed pursuant to this article shall comprehensively study and research the long-term care system and develop recommendations for legislation improving the long-term care system in this state.

26-4.6-102. Definitions. As used in this article, unless the context otherwise requires:

(1) "Community-based" means services provided in an individual's home or in a home-like setting. "Community-based" does not include a hospital, skilled nursing facility, intermediate care facility, or nursing home.

(2) "Continuum of care" means an organized system of care, benefits, and services to which a client has access and

which enables a client to move from one level or type of care to another without encountering gaps or barriers in service.

(3) "Home and community-based services" has the same meaning as that set forth in section 26-4.5-103 (5).

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

26-4.6-103. Task force on long-term health care - creation - issues to be studied. (1) In order to provide legislative overview of and study of the long-term care system in this state and to develop recommendations for legislation improving the long-term care system, there is hereby established the task force on long-term health care. The membership of the task force shall consist of twenty-five members. The speaker of the house of representatives and the president of the senate shall appoint six legislators, representing each political party, to serve on the task force and shall appoint one of those six members to serve as the chairman. The speaker of the house of representatives and the president of the senate shall appoint six members who shall be knowledgeable about long-term health care issues and who represent agencies and associations of hospitals, nursing

homes, home health or other types of home and community-based caregivers, physicians, and dietitians. The speaker of the house of representatives and the president of the senate shall appoint six members who are knowledgeable in the concerns and special needs of the following special populations requiring long-term health care: Stroke patients; chronically mentally ill persons; spinal cord and head injured persons; disabled infants; persons with Alzheimer's disease or other dementing illnesses; and persons with acquired immune deficiency syndrome. The speaker of the house of representatives and the president of the senate shall appoint two members who are knowledgeable about long-term health care issues and who represent associations which serve as advocates for the elderly. The executive directors of the departments of health, social services, and institutions or their designees shall also be members of the task force. The executive director of the university of Colorado health sciences center or his designee and the state nursing home ombudsman shall also be members of the task force. Appointments to the task force shall be made no later than July 1, 1988.

(2) The task force shall study and address the following issues: Case management; case mix reimbursement system; client assessment; development of the long-term care access system; innovative funding mechanisms, including but not limited to long-term care insurance, social health maintenance organizations, reverse home equity programs, individual medical accounts, tax incentives, and sources of private and

public funds; rate and reimbursement methodology for community-based and institutional services; the needs of special populations of persons requiring long-term care; the roles of the state, local governments, and the private sector; the integration of programs and services into a continuum of care; disabled adult protection; shortages of physical therapists and other health care providers; methods to ensure adequate standards for board and care and to provide quality of care for patients; support of family caregivers; respite care services; nursing home regulations; diagnosis and treatment of certain diseases and conditions, including acquired immune deficiency syndrome; education and training of the public and of caregivers; development of specific programs for Alzheimer's disease; reimbursement for those persons under the age of sixty-five; the need for the development of nutrition services to prevent chronic disease and improve the general health of citizens; nutrition and education training; reimbursement of dietetic services under insurance laws; and any other relevant issues.

(3) Unless extended beyond July 1, 1991, the task force shall make its final report to the general assembly on its recommendations for legislation concerning the long-term care system on or before January 1, 1991.

(4) In addition to the issues studied in subsection (2) of this section, the task force is specifically required to address and report back to the general assembly and to the state department annually upon the progress of and make

recommendations concerning the following:

(a) The development and presentation of a unified long-term care plan and budget, including all programs, services, and state expenditures falling under the continuum of long-term care for the state fiscal year 1990-91 and for each subsequent fiscal year; and

(b) The development and incremental implementation of such administrative and management procedures, such as performance-based contracting and quality control systems and case management agency designation, as may be useful in the operation of a cost-effective, accountable, and safe continuum of long-term care, and as may promote the development of consortiums and the development of agencies at community or regional levels and encourage the use of public or private contractors which will optimally meet the needs and utilize the available resources of each community.

(5) The task force shall create a subcommittee on Alzheimer's disease and on any other topics it deems necessary. The subcommittee on Alzheimer's disease shall:

(a) Study all aspects of Alzheimer's disease from diagnosis through treatment, cure, and research, and the impacts of the disease on the health care system, family systems, social support system, and financing system;

(b) Consider the current interaction of relevant policies and programs and make recommendations for improvements and methods to improve coordination and reduce duplication of effort;

(c) Review available data and recommend other types of data that would be useful to collect;

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

(6) The task force shall meet when necessary with representatives of the departments of social services, health, and institutions and may consult with other experts and interested groups as may be necessary. The staffs of the legislative council and of the state auditor shall assist the committee.

26-4.6-104. Private sources of funding. The task force on long-term health care is authorized to receive contributions, grants, services, and in-kind donations from private sources and may use such donations to pay for the direct and indirect costs of research and to compensate nonprofit agencies and private groups who assist the task force by supplying staff support.

26-4.6-105. Repeal. This article is repealed, effective July 1, 1991.

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

Bill 2

Interim Committee on
Long-term Health Care Needs

A BILL FOR AN ACT

CONCERNING THE IMPLEMENTATION OF A CONTINUUM OF CARE FOR ELDERLY AND DISABLED PERSONS WHO REQUIRE LONG-TERM CARE, AND MAKING AN APPROPRIATION IN CONNECTION THEREWITH.

Bill Summary

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

Authorizes the implementation of the following optional basic services for the categorically needy if the executive director of the department of social services determines that the services are cost-effective: Private duty nursing; ventilator services; hospice benefit services; case management services; and personal care. Permits a program to be implemented, when cost-effective, to provide medicaid personal care services for persons who are receiving or are eligible to receive a home care allowance.

Requires the department of social services to develop a long-term client needs assessment instrument to determine the client's care needs and the method of payment for such needs. Requires nursing homes to refer all nursing home applicants to a voluntary preadmission needs assessment review which would determine the client's needs and inform the client of alternatives to nursing home care. Authorizes the department of social services to collect a fee (which may be reimbursed by private or public sources) for such preadmission review from the applicant. Provides that, if a nursing home fails to refer an applicant for preadmission review and the person is admitted to a nursing home and subsequently qualifies for medical assistance or other state-funded assistance, the department of social services may deny payment to the nursing home for that client for a certain period of time.

Authorizes the department of social services to conduct a pilot project to study the coordination of and access to long-term care services at the community level. Makes an appropriation to the department of social services to implement this act.

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

SECTION 1. 26-4-105 (1), Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended BY THE ADDITION OF THE FOLLOWING NEW PARAGRAPHS to read:

26-4-105. Basic services for categorically needy. (1) (q) Private duty nursing;

(r) Services to individuals who are ventilator dependent;

(s) Hospice benefit services;

(t) Case management services;

(u) Personal care.

SECTION 2. Article 4 of title 26, Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SECTION to read:

26-4-105.3. Optional services for categorically needy - cost-effective. (1) Subject to a finding by the executive director that one or more of the basic services for categorically needy as provided in section 26-4-105 (1) (q) to (1) (u) are cost-effective, the state department may provide one or more of the following basic services for the categorically needy:

(a) Private duty nursing;

(b) Services to individuals who are ventilator

dependent;

(c) Hospice benefit services;

(d) Case management services;

(e) Personal care.

(2) In implementing personal care services pursuant to paragraph (e) of subsection (1) of this section, the state department may implement, when it is cost-effective, a program to provide medicaid personal care services to persons who are receiving or are eligible to receive a home care allowance as authorized in section 26-2-114 (2).

SECTION 3. 26-4.5-103, Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended BY THE ADDITION OF THE FOLLOWING NEW SUBSECTIONS to read:

26-4.5-103. Definitions. (1.5) "Care plan" means a plan for long-term care services.

(4.5) "Client needs assessment" means a procedure and methodology for objectively measuring and analyzing an individual's entire range of needs for long-term care, including, but not limited to, functional, medical, psychosocial, and environmental needs.

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

individuals.

(14.5) "Nursing home" means a facility which provides skilled nursing home services or intermediate care nursing home services.

SECTION 4. Part 1 of article 4.5 of title 26, Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended BY THE ADDITION OF THE FOLLOWING NEW SECTIONS to read:

26-4.5-116. Long-term care client needs assessment - preadmission reviews - fee - penalty for failure to refer applicants. (1) The state department shall develop and implement by July 1, 1990, a long-term care client needs assessment instrument for all individuals needing long-term care. This instrument shall be used to determine which long-term care services a client needs and who will pay for such services and to assist individuals in developing a care plan.

(2) The state department shall make available as a voluntary program a system of preadmission needs assessment review to all persons applying for admission to a nursing home, whether or not such person is a recipient of public assistance or is expected to finance the nursing home stay with private funds. The purpose of such preadmission review is to determine the care needs of the individual and the appropriate level of care to meet the individual's needs, inform the individual prior to his becoming institutionalized about alternatives to nursing home care which would appropriately meet his care needs, and allow the individual

and his family to make a more informed decision about whether the individual should enter a nursing home facility or should choose a less expensive and less restrictive level of care. An individual who is or will be paying privately for nursing home care is not obligated to participate in the preadmission review. A reasonable fee for such preadmission review shall be set by the state department by rule and regulation. Such fee shall be paid by the individual applying for nursing home admission; except that such requirement shall not preclude coverage of such fee through private insurance, medical assistance, or other public funding. Nursing homes shall refer all applicants for preadmission review to the agency designated by the state department. If a nursing home fails to refer an applicant for such preadmission review and if that individual enters the nursing home and subsequently applies and qualifies for medical assistance or other state-funded nursing home care reimbursement, the state department may deny payment to the nursing home for up to six months for that client. The nursing home shall not deny appropriate care and admission to the client for that period and shall not bill or otherwise recover from the patient or his family or estate or assigns the cost of such care or admission.

26-4.5-117. Long-term care access system pilot project. (1) The state department shall implement and study a pilot project on a long-term care access system which provides for coordination of care services at the community level and is available to all persons needing long-term care. This system

would provide client needs assessment, payment resource coordination, and care planning and referral through local governments or private agencies in the local community under agreements with the state department.

(2) The state department shall report annually to the general assembly on the progress and effectiveness of the pilot project.

(3) This section is repealed, effective July 1, 1992.

SECTION 5. Appropriation. (1) In addition to any other appropriation, there is hereby appropriated, out of any moneys in the general fund not otherwise appropriated, to the department of social services, the sum of eight hundred nine thousand eight hundred seventy-one dollars ($809,871) and 1.25 FTE, or so much thereof as may be necessary, for the implementation of private duty nursing services and services to individuals who are ventilator dependent.

(2) In addition to any other appropriation, there is hereby appropriated, to the department of social services, for the fiscal year beginning July 1, 1988, the sum of forty-nine thousand four hundred seventy-eight dollars ($49,478) and 2.0 FTE, or so much thereof as may be necessary, of which total sum, twenty-four thousand seven hundred thirty-nine dollars ($24,739) shall be out of any moneys in the general fund not otherwise appropriated and twenty-four thousand seven hundred thirty-nine dollars ($24,739) shall be from federal funds, for the implementation of personal care services.

(3) In addition to any other appropriation, there is

hereby appropriated, to the department of social services, for the fiscal year beginning July 1, 1988, the sum of eighty-three thousand three hundred fifty-nine dollars ($83,359) and 2.0 FTE, or so much thereof as may be necessary, of which total sum, twenty thousand eight hundred forty dollars ($20,840) shall be out of any moneys in the general fund not otherwise appropriated and sixty-two thousand five hundred nineteen dollars ($62,519) shall be from federal funds, for the implementation of the preadmission needs assessment review.

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.

Bill 3

Interim Committee on
Long-term Health Care Needs

A BILL FOR AN ACT

CONCERNING THE STUDY OF CASE MANAGEMENT SERVICES, AND PROVIDING FOR A LEGISLATIVE-INTERAGENCY TASK FORCE ON CASE MANAGEMENT AND A PILOT PROJECT FOR AN INDEPENDENT CASE MANAGEMENT SYSTEM, AND MAKING AN APPROPRIATION IN CONNECTION THEREWITH.

Bill Summary

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

Creates a legislative-interagency task force to study the delivery, administrative structure, and financing implications of case management services for all disabled persons; the feasibility and cost-effectiveness of an independent case management system serving clients of the departments of education, health, institutions, and social services; the ongoing citywide case management demonstration project; the delivery of case management in all areas of the state; and a pilot project authorized by this act. Requires the task force to report on its findings to the general assembly on a certain date. Defines case management for the purposes of this act.

Authorizes the department of institutions to develop and administer a pilot project on case management for chronically mentally ill persons and emotionally disturbed youth which shall be located in the rural areas of the state. Directs that such pilot project shall be an independent system which uses a team management model and a local advisory board. Authorizes the department of institutions to receive grants, donations, and services from private sources to pay for the costs of the pilot project on case management.

Makes an appropriation to the department of institutions to implement this act.

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

SECTION 1. Part 1 of article 1 of title 27, Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended BY THE ADDITION OF THE FOLLOWING NEW SECTIONS to read:

27-1-110. Task force on case management. (1) There is hereby created a legislative-interagency task force on case management which shall study the delivery of services through case management. There shall be fifteen members of the task force. The speaker of the house of representatives shall appoint two legislators from the house of representatives, representing each political party, to serve on the task force. The president of the senate shall appoint two legislators from the senate, representing each political party, to serve on the task force. The governor shall appoint five members, who shall represent advocacy groups concerned with the interests of the mentally ill, developmentally disabled, and the elderly. The governor shall appoint two members who represent providers of mental health services. The commissioner of education and the executive directors of the department of health, department of social services, and department of institutions or their designees shall also be members of the task force. The members of the task force shall serve without compensation.

(2) The task force shall study the following:

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

(b) The feasibility and cost-effectiveness of establishing an independent case management entity for all persons with disabilities which would serve clients of the departments of education, health, institutions, and social services;

(c) The citywide case management demonstration project operated in the city and county of Denver;

(d) The delivery of case management services in urban, suburban, and rural areas of the state;

(e) The pilot project on case management as set forth in section 27-1-111.

(3) The task force shall report the results of its study and make any recommendations to the general assembly on or before January 1, 1990.

(4) For purposes of this section and section 27-1-111, "case management" means a single point of entry and coordination of services with uniform eligibility requirements, an assessment of the individual's strengths and weaknesses, a coordinated plan for needed services developed by the individual, family members, when appropriate, and an inter-disciplinary team with goals and measurable objectives, periodic review, and ongoing monitoring of the service delivery. Case management may be developed as an independent system in which the case manager acts as an advocate for the

individual and serves as a broker to locate and purchase appropriate services for the individual. Case management may also be developed in conjunction and cooperation with the direct service providers.

(5) This section is repealed, effective July 1, 1990.

27-1-111. Pilot project on case management. (1) The department of institutions shall develop and administer a pilot project on case management for chronically mentally ill persons and emotionally disturbed youth located in a rural area or areas of the state. Such pilot project shall be an independent system in which the case manager acts as an advocate for the individual and serves as a broker to locate and purchase appropriate services for the individual. Such project shall use a case management team leader and a case management team supervised by the division of mental health and assisted by a local advisory board comprised of family members of chronically mentally ill persons, recovering chronically mentally ill persons, and mental health advocates.

(2) For purposes of this section, "case management" has the same meaning as defined in section 27-1-110 (4).

(3) This section is repealed, effective July 1, 1990.

27-1-112. Private sources of funds. (1) The department of institutions is authorized to receive contributions, grants, services, and in-kind donations from private sources and may use such donations to pay for all or some of the costs of the pilot project on case management as specified in section 27-1-111.

(2) This section is repealed, effective July 1, 1990.

SECTION 2. Appropriation. In addition to any other appropriation, there is hereby appropriated, to the department of institutions, for the fiscal year beginning July 1, 1988, the sum of thirty-six thousand dollars ($36,000), or so much thereof as may be necessary, for the implementation of this act. Of such total sum, eighteen thousand dollars ($18,000) shall be from the general fund and eighteen thousand dollars ($18,000) shall be transferred from line items appropriated to the division of mental health as determined by the executive director of the department of institutions.

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

Bill 4

Interim Committee on
Long-term Health Care Needs

A BILL FOR AN ACT

CONCERNING PERSONS EMPLOYED AS NURSES' AIDES BY CERTAIN SKILLED AND INTERMEDIATE NURSING FACILITIES.

Bill Summary

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

Prohibits the employment of any person as a nurses' aide in a skilled or intermediate nursing facility unless that person has completed a specified period of nurses' aide instruction or the number of hours required by federal regulations for certification as a nurses' aide or unless that person has worked in one such facility before a certain date. Allows the department of health to suspend, revoke, or deny an application for a license to operate any such facility which employs nurses' aides who do not meet the instructional or experience requirements. Prohibits contract service employee services from providing to skilled or intermediate nursing facilities nurses' aides who are not certified. Requires the state board for community colleges and occupational education to certify nurses' aides, to approve nurses' aide instructional programs, and to promulgate rules and regulations relevant to nurses' aide training and certification. Allows the required instruction to be given by public or private schools, health care providers, or other entities. Prohibits a skilled or intermediate nursing facility from reducing the pay of an employee in order to pay for nurses' aide instruction or from requiring such an employee to attend such instruction during the employee's nonwork time.

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

SECTION 1. Part 1 of article 3 of title 25, Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SECTION to read:

25-3-109. Nurses' aides - training - certification. (1) Beginning July 1, 1989, no person shall be employed as a nurses' aide in any skilled or intermediate nursing facility unless:

(a) Such person has successfully completed the greater of eighty hours of instruction for nurses' aides as approved by the state board for community colleges and occupational education pursuant to section 23-60-307, C.R.S., or the minimum number of hours of such instruction required by federal regulations or statutes for certification as a nurses' aide; or

(b) Such person has worked in a single skilled or intermediate nursing facility prior to July 1, 1988.

(2) Notwithstanding the provisions of subsection (1) of this section, a person who is not certified as a nurses' aide on the date of his employment may be employed as a nurses' aide if he begins the instruction required by paragraph (a) of subsection (1) of this section within three months after his initial employment. Any such person may continue his employment as a nurses' aide beyond six months after his initial employment only if he is certified within such six-month period. Such person shall not perform any patient care duties without supervision by trained personnel until he

has successfully completed instruction for that patient care duty.

(3) The state board for community colleges and occupational education shall approve the instructional programs required by subsection (1) of this section and shall issue certificates to nurses' aides who have met the requirements of subsection (1) of this section and applied for certification. The instructional programs required by subsection (1) of this section may be given by public or private schools, health care providers, or other entities. When written language is a barrier to a nurses' aide trainee, the nurses' aide instructional program examinations shall be oral.

(4) No skilled or intermediate nursing facility shall require an employee who is taking an instructional program required for nurses' aides by subsection (1) of this section to take a reduction in pay in order to pay for such instructional program, nor shall such an employer require an employee to attend such an instructional program during the employee's nonwork time.

(5) On or after July 1, 1989, the department of health may suspend, revoke, or deny an application for a license to operate any skilled or intermediate nursing facility which violates the provisions of subsection (1) or (2) of this section.

(6) On or after April 1, 1989, any service or business which provides contract service employees to skilled or

intermediate nursing facilities shall not provide any contract service employee to any such facility to be employed as a nurses' aide unless such person has been certified as a nurses' aide pursuant to this section.

(7) This section is repealed, effective July 1, 1991.

SECTION 2. Part 3 of article 60 of title 23, Colorado Revised Statutes, as amended, is amended BY THE ADDITION OF A NEW SECTION to read:

23-60-307. Nurses' aide education. (1) The board shall administer and coordinate the training and certification of nurses' aides in the state, pursuant to section 25-3-109, C.R.S., including the approval of instructional programs and the issuance of nurses' aide certificates. The board shall have the authority to promulgate rules and regulations relevant to nurses' aide training and certification.

(2) This section is repealed, effective July 1, 1991.

SECTION 3. Effective date. This act shall take effect July 1, 1988.

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

Bill 5

Interim Committee on Long-term
Health Care Needs

A BILL FOR AN ACT

CONCERNING AN EXTENSION OF THE HOURS DURING WHICH THE DEPARTMENT OF HEALTH MAY INSPECT HEALTH CARE FACILITIES.

Bill Summary

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

Allows the department of health to inspect general hospitals, hospital units as defined in section 25-3-101 (2), psychiatric hospitals, community clinics, rehabilitation centers, convalescent centers, community mental health centers, facilities for the mentally retarded, habilitation centers for brain-damaged children, chiropractic centers and hospitals, maternity hospitals, nursing care facilities, intermediate care facilities, residential care facilities, the pilot project rehabilitative nursing facility, hospice care facilities for terminally ill individuals, personal care boarding homes, and other institutions of a like nature on any day of the week at any time.

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

SECTION 1. 25-1-107 (1) (l) (I), Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended to read:

25-1-107. Powers and duties of the department. (1) (l) (I) To annually license and to establish and enforce standards for the operation of general hospitals, hospital

units as defined in section 25-3-101 (2), psychiatric hospitals, community clinics, rehabilitation centers, convalescent centers, community mental health centers, facilities for the mentally retarded, habilitation centers for brain-damaged children, chiropractic centers and hospitals, maternity hospitals, nursing care facilities, intermediate care facilities, residential care facilities, the pilot project rehabilitative nursing facility, hospice care facilities for terminally ill individuals, personal care boarding homes, and other institutions of a like nature, except those wholly owned and operated by any governmental unit or agency. In establishing and enforcing such standards and in addition to the required announced inspections, the department shall, within available appropriations, make additional inspections without prior notice to the facility. Such inspections ~~shall be made only during the hours of 7 a.m. to 7 p.m.~~ MAY BE MADE ON ANY DAY OF THE WEEK AT ANY TIME. The issuance, suspension, renewal, revocation, annulment, or modification of licenses shall be governed by the provisions of sections 24-4-104, C.R.S., and 25-3-102, and all licenses shall bear the date of issue and cover a twelve-month period. Nothing contained in this paragraph (1) shall be construed to prevent the department from adopting and enforcing, with respect to projects for which federal assistance has been obtained or shall be requested, such higher standards as may be required by applicable federal laws or regulations of federal agencies responsible for the administration of such

federal laws.

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

Bill 6

Interim Committee on Long-term
Health Care Needs

A BILL FOR AN ACT

CONCERNING THE ESTABLISHMENT OF A QUALITY CARE INCENTIVE ALLOWANCE FOR LONG-TERM HEALTH CARE PROVIDERS, AND MAKING AN APPROPRIATION THEREFOR.

Bill Summary

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

Establishes a quality care incentive allowance to be distributed to nursing care and intermediate nursing facilities which have a high level of quality care. Creates an advisory board, appointed by the speaker of the house of representatives, the president of the senate, and the governor, to develop a three-star rating system of the nursing facilities, based on survey information gathered for medicaid certification. Makes an appropriation.

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

SECTION 1. Article 4 of title 26, Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SECTION to read:

26-4-110.3. Quality care incentive allowance. (1) In order to encourage quality and efficiency in Colorado's health care system and to provide information to the public regarding

the quality of care furnished by providers, there is hereby established a quality care incentive allowance, which shall be distributed to those eligible long-term health care providers which furnish a high quality of care.

(2) (a) There is hereby created an advisory committee on quality care, referred to in this section as the "committee", to develop a three-star rating system of nursing care and intermediate nursing facilities which receive payments pursuant to this article. Such rating system shall be based on the results of the recertification surveys required for facilities to receive funds pursuant to this article. The committee shall consist of no more than nine members, two of whom shall be members of the house of representatives, one from each major party, appointed by the speaker of the house; two of whom shall be members of the senate, one from each major party, appointed by the president of the senate; one of whom shall be the state long-term care ombudsman; and four of whom shall be be appointed by the governor, with one appointee representing each of the following groups: The department of health, the state department, the long-term care industry, and consumers.

(b) There is hereby created the quality care incentive allowance fund, which shall consist of moneys deposited thereto pursuant to section 26-4-110 (5) (c). The general assembly shall make annual appropriations from the fund to the committee to be distributed to nursing care facilities which provide high-quality long-term care. Any moneys not

appropriated shall remain in the fund and shall not be transferred or revert to the general fund of the state at the end of any fiscal year.

(c) The committee shall devise a formula for the distribution of moneys from the quality care incentive allowance fund to encourage and reward the providers of high quality long-term care. No facility which was found in the most recent medicaid recertification survey to be deficient in an entire category of standards measured for participation under federal medicaid rules shall be eligible for any quality care incentive allowance. Any facility which employs any nurses' aides who do not meet the requirements for instruction and certification of nurses' aides, if any, pursuant to part 1 of article 3 of title 25, C.R.S., or in federal statute or regulation shall not be eligible to receive quality care allowance payments. The amount of an eligible facility's quality care incentive allowance shall be based only on quality categories dealing with direct patient care. The department of health shall provide the necessary survey information to the state department and the advisory committee.

SECTION 2. 26-4-110 (5) (c), Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended to read:

26-4-110. Vendors - payments - rules. (5) (c) The state board shall, subject to available appropriations, adopt rules and regulations to determine and pay a reasonable share of the amount by which the reasonable costs of the categories

of administration, property, and room and board, excluding food costs, exceed the actual cost in these categories only of each facility. Such reasonable share shall be defined as twenty-five percent of such amount in such categories for each facility, not to exceed twelve percent of the reasonable cost. ONE-HALF OF THIS AMOUNT SHALL BE DISTRIBUTED TO THE FACILITY AND ONE-HALF SHALL BE DEPOSITED IN THE QUALITY CARE INCENTIVE ALLOWANCE FUND CREATED BY SECTION 26-4-110.3 AND DISTRIBUTED IN ACCORDANCE WITH THE PROVISIONS OF SAID SECTION.

SECTION 3. Appropriation. In addition to any other appropriation, there is hereby appropriated, out of any moneys in the quality care incentive allowance fund not otherwise appropriated, to the department of social services, for the fiscal year beginning July 1, 1988, the sum of _____ dollars ($), or so much thereof as may be necessary, for the implementation of this act.

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

Bill 7

Interim Committee on Long-term Health Care

A BILL FOR AN ACT

CONCERNING INCENTIVE PAYMENTS TO NURSING FACILITIES WHICH SUCCESSFULLY DISCHARGE MEDICAID PATIENTS, AND MAKING AN APPROPRIATION IN CONNECTION THEREWITH.

Bill Summary

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

Directs the department of social services to establish a pilot program to provide incentives to nursing facilities to discharge medicaid patients. Provides that any such facility which discharges a medicaid patient who is not readmitted to a similar or higher level facility for a related disorder for a specified period shall receive a payment equal to a specified multiple of the reasonable cost per day for the discharged patient in the discharging facility. Provides that the program is eliminated after a certain date. Makes an appropriation.

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

SECTION 1. Article 4 of title 26, Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SECTION to read:

26-4-110.7. Discharge incentive - pilot project. (1) The state department shall establish a discharge

incentive pilot program which provides an incentive for the nonpunitive-related discharge of recipients to an appropriate and safe living environment and which covers some of the costs associated with that discharge by providing a payment to a nursing care facility or an intermediate nursing facility which successfully discharges a recipient.

(2) Under the pilot program, any nursing care facility or intermediate nursing facility that discharges a recipient shall receive a payment equal to fifteen times the reasonable cost per day for that facility for the recipient who was discharged, but only if the recipient is not readmitted to a nursing care or an intermediate nursing facility or to a facility which provides a higher level of care for a related disorder for sixty days after discharge.

(3) Pursuant to article 4 of title 24, C.R.S., the state department shall adopt rules and regulations for the administration of this section.

(4) The state department shall contract with an agency with health services evaluation experience for evaluation of the pilot program established by this section and shall present a report of such evaluation to the general assembly not later than January 1, 1989.

(5) This section is repealed, effective July 1, 1989.

SECTION 2. Appropriation. In addition to any other appropriation, there is hereby appropriated, out of any moneys in the general fund not otherwise appropriated, to the department of social services, for the fiscal year beginning

July 1, 1988, the sum of ten thousand dollars ($10,000), or so much thereof as may be necessary, for the implementation and administration of the discharge incentive pilot program established in section 26-4-110.7, Colorado Revised Statutes.

SECTION 3. Effective date. This act shall take effect July 1, 1988.

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

Bill 8

Interim Committee on Long-term Health Care Needs

A BILL FOR AN ACT

CONCERNING METHODS TO ENCOURAGE THE DEVELOPMENT OF CHILD CARE CENTERS IN NURSING HOME FACILITIES, AND MAKING AN APPROPRIATION IN CONNECTION THEREWITH.

Bill Summary

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

Creates a grant program administered by the department of health to provide start-up funds to nursing home facilities to establish a child care center. Specifies that the grants shall be distributed on a first-come-first-served basis to nursing home facilities which are approved by the department of health and which have obtained matching funds. Specifies the requirements that an applicant shall meet for approval for a grant.

Requires the departments of health and social services, in conjunction with the nursing home industry, child care operators, and experts on child care in nursing home facilities, study the existing statutes and regulations on licensing child care centers and nursing home facilities to determine and report to the general assembly about statutory changes which would facilitate the operating of child care centers in nursing home facilities. Such study shall examine a program which would allow for waiver of nursing home licensure regulations and a separate licensure program for operating a child care center in a nursing home facility.

Makes an appropriation to the department of health to implement this act.

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

SECTION 1. Article 1 of title 25, Colorado Revised Statutes, 1982 Repl. Vol., is amended BY THE ADDITION OF A NEW PART to read:

PART 10

CHILD CARE PROGRAMS IN

NURSING HOME FACILITIES

25-1-1001. Legislative declaration. The general assembly hereby finds that the operation of child care centers in nursing home facilities is desirable because the benefit to nursing home facility employees in having on-location child care at no cost will improve the quality of care in nursing home facilities by stabilizing the nursing home work force. The general assembly also finds that the operation of child care centers in nursing home facilities is desirable because the intergenerational contact has been proven to be beneficial to the health and well-being of elderly persons and, therefore, will improve the quality of life of elderly residents in nursing home facilities. The general assembly, therefore, declares that the intent of this part 10 is to encourage the development of child care centers in nursing home facilities by creating a grant program to provide funds to start such centers and by requiring the state agencies which license nursing home facilities and child care centers to study and recommend statutory and regulatory changes to facilitate and encourage the development of child care centers in nursing home facilities.

25-1-1002. Definition. As used in this part 10, unless the context otherwise requires:

(1) "Nursing home facility" means a facility which provides skilled nursing home services or intermediate care nursing home services.

25-1-1003. Grant program - requirements. (1) The department of health shall implement a grant program to provide start-up funds to nursing home facilities for the purpose of establishing child care centers located in such nursing home facilities. The grants shall be distributed on a first-come-first-served basis to nursing home facilities which are approved by said department. Each grant awarded shall be ten thousand dollars or less, and, as a condition of receiving such grant, an applicant shall submit proof that it has obtained matching funds for the purpose of implementing the child care center.

(2) The state board of health, after consultation with the division in the department of social services involved in licensing child care centers, shall promulgate reasonable rules and regulations establishing the requirements for obtaining a grant pursuant to this section. Such rules and regulations shall include, but need not be limited to, the following requirements:

(a) The applicant shall demonstrate the ability to operate a safe and good-quality child care operation in the nursing home facility or upon the nursing home facility's grounds.

(b) The applicant shall demonstrate the ability to properly care for the children.

(c) The applicant shall meet certain standards, as established by the state board of health, on the quality of care provided to nursing home residents.

(d) The applicant shall demonstrate that the child care program and the actual facility in which the child care center is located will conform to necessary rules and regulations required by law, including such things as the child care ratio of staff to children and life safety and fire regulations.

(e) The applicant shall submit proof that the nursing home facility will be able to obtain affordable liability insurance to insure the risks associated with the child care operation.

(f) The applicant shall submit a plan which describes the program, the ways in which the nursing home residents will be involved in the child care center, and the ways in which nursing home residents can voluntarily participate in intergenerational activities with the children in the child care operation.

(g) The applicant shall agree that any children of employees of the nursing home facility who are accepted in the child care program will be accepted free of charge.

25-1-1004. Study of statutes and rules and regulations pertaining to nursing home facilities and day care centers. (1) The department of health and the department of social services, in conjunction with representatives of the nursing

home industry, child care operators, and experts on child care programs in nursing home facilities, shall examine and study the existing statutes and rules and regulations concerning the licensing of child care centers and of nursing home facilities to determine what statutory or regulatory changes or both would make it easier for a nursing home facility to operate a child care center.

(2) The study conducted by the department of health and the department of social services shall include, but need not be limited to, an examination of the following:

(a) A waiver program which would allow for the waiver of certain licensing requirements of the department of health for nursing home facilities which meet a certain level of quality in serving nursing home residents and which demonstrate that the facility would be able to provide a safe and good-quality child care operation that would be beneficial to the nursing home residents;

(b) A separate licensure program to license a child care operation in a nursing home facility which would be based on rules and regulations designed specifically for the operation of a child care center in a nursing home facility.

(3) The department of health and the department of social services shall report on the results of such study and make recommendations to the general assembly about the most appropriate methods for facilitating the development and operation of child care programs in nursing home facilities on or before January 1, 1989.

SECTION 2. Appropriation. In addition to any other appropriation, there is hereby appropriated, out of any moneys in the general fund not otherwise appropriated, to the department of health, for the fiscal year beginning July 1, 1988, the sum of one hundred thousand dollars ($100,000), or so much thereof as may be necessary, for the implementation of this act.

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

Bill 9

Interim Committee on
Long-term Health Care Needs

A BILL FOR AN ACT

CONCERNING THE INSPECTION OF X-RAY PRODUCING MACHINES, AND MAKING AN APPROPRIATION IN CONNECTION THEREWITH.

Bill Summary

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

Requires the state board of health to promulgate rules and regulations establishing standards for x-ray producing machines, the qualifications of persons authorized to inspect and certify such machines, and the procedures for an annual inspection for all types of x-ray producing machines. Sets forth certain procedures for the inspections.

Requires annual inspections of x-ray producing machines to be made by qualified inspectors approved by the department; except that the department may make or contract for audit inspections to assure compliance with the specifications.

Declares that the setting of minimum specifications for x-ray producing machines and standards for approval of inspectors is a matter of statewide concern.

Creates a misdemeanor for knowingly using any machine which is a source of ionizing radiation which is not certified as provided in this act. Provides for disciplinary action against any qualified inspector who incorrectly certifies an x-ray producing machine as meeting the standards.

Changes the name of the radioactive materials control fund to the radiation control fund. Authorizes the collection of a fee for the approval of persons to be inspectors and for a certification or noncertification sticker affixed to the x-ray producing machine after inspection. Makes an appropriation to the department of health to implement this act.

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

SECTION 1. 25-11-104 (6) (c), Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended, and the said 25-11-104 is further amended BY THE ADDITION OF A NEW SUBSECTION, to read:

25-11-104. Rules and regulations to be adopted - fees - fund created. (6) (c) All fees collected pursuant to this subsection (6) shall be transmitted to the state treasurer who shall credit the same to the ~~radioactive--materials~~ RADIATION control fund, which fund is hereby created. Moneys credited to said fund, in amounts determined annually by the general assembly by appropriation, shall be expended for radiation control services as provided in this subsection (6).

(8) (a) The state board of health shall adopt rules and regulations requiring that all machine sources of ionizing radiation which are used for therapeutic or diagnostic use on humans be annually inspected and certified by qualified inspectors as safe for the intended uses and in compliance with the specifications of the state board of health and the equipment manufacturer. Such rules shall include the following:

(I) The establishment of minimum specifications that each type of machine which is a source of ionizing radiation shall meet. Such specifications shall include compliance with the manufacturer's specifications and any additional specifications of the state board of health which are

necessary to determine that the machine is safe for its designed and intended use.

(II) The establishment of minimum standards for the qualification of individuals who are authorized to make inspections and to certify machines which are sources of ionizing radiation. Other than those individuals performing emergency inspections or inspection audits for the department, qualified inspectors shall not be employees of the department. The maximum fee which may be charged by the department to an individual seeking approval as a qualified inspector is fifty dollars. Such fee shall include the issuance of evidence of qualification, if applicable, and all other costs for qualifications. The maximum fee for annual renewal shall be twenty-five dollars. Such fees shall be credited to the radiation control fund.

(III) The establishment of procedures for the making of annual inspections for all types of machines which are sources of ionizing radiation. The procedures shall require that such machines be inspected only by a qualified inspector who shall record on a form provided by the department whether or not a machine being inspected meets the specifications of the manufacturer and the state board of health, and shall indicate the type of machine, the applicable specifications, and the machine specifications. If a machine meets the required specifications, a qualified inspector shall affix on the machine an official sticker issued by the department. If the machine fails to meet the required specifications, the

qualified inspector shall notify the owner or operator immediately and shall so notify the department within three days. A machine which fails to meet the required specifications shall not be used thereafter for human use until subsequent certification, and the qualified inspector shall affix an official noncertification sticker issued by the department indicating such machine is not authorized for human use. A certification or noncertification sticker shall be affixed on each machine in a location conspicuous to machine operators and persons on whom the machine is used. A fee of ten dollars shall be charged for each certification or noncertification sticker issued by the department. Such fee shall be credited to the radiation control fund.

(b) The department may make or contract for the making of audit inspections of machines which are sources of ionizing radiation to assure compliance with applicable specifications. Such audit inspections shall be made by a qualified inspector on machines which are currently certified by a qualified inspector. Audit inspections shall be conducted on only a portion of all certified machines and shall be made on a routine, unannounced basis. The cost of the audit inspections shall be paid for out of the radiation control fund.

(c) In establishing or revising specifications for each type of machine which is a source of ionizing radiation, the standards for approval of qualified inspectors, and the procedures for making inspections, the department shall consult with manufacturers of ionizing radiation equipment,

health care providers and operators who use such equipment in diagnostic and therapeutic treatment of humans, and qualified inspectors and individuals.

(d) The general assembly hereby finds that the setting of minimum specifications for machines which are sources of ionizing radiation and the establishment of minimum standards for qualified inspectors for such machines is a matter of statewide concern. Therefore, no other state agency, political subdivision, or local government shall establish any other specifications for sources of ionizing radiation or standards for inspectors of such equipment, or impose any fees therefor.

SECTION 2. 25-11-107 (3), Colorado Revised Statutes, 1982 Repl. Vol., is amended, and the said 25-11-107, as amended, is further amended BY THE ADDITION OF THE FOLLOWING NEW SUBSECTIONS, to read:

25-11-107. Prohibited acts - violations - penalties. (2.5) No person shall knowingly use any machine which is a source of ionizing radiation which is not certified as provided in section 25-11-104 (8).

(3) Any person who violates the provisions of ~~subsections~~ SUBSECTION (1), ~~and~~ (2), OR (2.5) of this section is guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not less than one hundred dollars nor more than five hundred dollars, or by imprisonment in the county jail for not less than thirty days nor more than ninety days, or by both such fine and imprisonment.

(6) Any qualified inspector who incorrectly certifies a machine which is a source of ionizing radiation as meeting the applicable specifications as required in section 25-11-104 (8) shall be subject to disciplinary provisions in accordance with section 24-4-104, C.R.S.

SECTION 3. Appropriation. In addition to any other appropriation, there is hereby appropriated, out of any moneys in the radiation control fund not otherwise appropriated, to the department of health, for the fiscal year beginning July 1, 1988, the sum of _____ dollars ($), or so much thereof as may be necessary, for the implementation of this act.

SECTION 4. Effective date. This act shall take effect July 1, 1988.

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

Bill 10

Interim Committee on Long-term Health Care Needs
BY SENATOR Hopper

A BILL FOR AN ACT

CONCERNING THE REPEAL OF PROVISIONS WHICH PROHIBIT THE DIRECT ACCESS OF THE PUBLIC TO PHYSICAL THERAPISTS.

Bill Summary

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

Allows the public to have direct access to a physical therapist for treatment by repealing a statute which prohibits a physical therapist from treating a patient without first obtaining a prescription or referral of a physician, dentist, or podiatrist. Repeals the definition of "prescription".

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

SECTION 1. Repeal. 12-41-102 (5) and 12-41-104 (1) (c), Colorado Revised Statutes, 1985 Repl. Vol., as amended, are repealed.

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

Bill 11

Interim Committee on Long-term Health Care Needs

A BILL FOR AN ACT

CONCERNING MEDICAL ASSISTANCE FOR THE PURPOSE OF PAYING THE COSTS OF NURSING HOME OR MEDICAL CARE.

Bill Summary

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

In determining eligibility for nursing home care under the medical assistance program, allows only the applicant's share of his and his spouse's total nonexempt resources and income to be considered. Establishes a presumption that such applicant has a one-half share in such resources and income. Establishes standards by which an applicant or spouse may rebut such a presumption. Requires the department of social services to establish standards for support of an applicant's spouse and residence. Gives the department of social services an enforceable right against certain spouses of recipients for the cost of medical assistance furnished to the recipient spouse.

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

SECTION 1. Article 4 of title 26, Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SECTION to read:

26-4-107.5. Eligibility of married applicants for medical assistance for nursing home care. (1) The general assembly hereby finds and declares that the standards used in

determining the eligibility of a married applicant for medical assistance often leave the spouse of the applicant with little income or resources. Therefore, it is the intent of the general assembly in enacting this section to protect a portion of the joint income and resources of a married couple when one spouse is institutionalized in a facility providing nursing home care, and they must apply for medical assistance to pay the cost of care in such a facility.

(2) When determining the eligibility of a married person who applies for medical assistance for the purpose of paying the cost of skilled nursing care services, intermediate care services, or any other type of nursing home care, the only portion of the nonexempt resources owned jointly by the applicant and his spouse which shall be considered available to the applicant shall be the applicant's interest in such resources. For the purposes of this subsection (2), there shall be a rebuttable presumption that each spouse has a one-half interest in such resources.

(3) When determining the eligibility of a married person who applies for medical assistance for the purpose of paying the cost of skilled nursing care services, intermediate care services, or any other type of nursing home care, the only portion of the income received by both the applicant and his spouse which shall be considered available to the applicant shall be the applicant's interest in such resources. For the purposes of this subsection (3), there shall be a rebuttable presumption that each spouse has a property interest in

one-half of the total monthly income of both spouses at the time of application for medical assistance.

(4) The presumption regarding the property interest of the applicant's spouse in the income or resources of both spouses may be rebutted by the applicant or his spouse only upon a showing of one of the following:

(a) A court order allocating income or resources pursuant to alimony, maintenance, spousal support, equitable division of marital property, or disposition of property;

(b) The establishment of sole individual interest in income resulting from current active employment; or

(c) A determination by the state department granting a supplementary allocation of spousal income or resources pursuant to subsection (5) of this section.

(5) The state department shall establish standards for the reasonable and adequate support of the nonapplicant spouse and the residence of the couple. The standards shall consider the cost of housing payments, property taxes, property insurance, utilities, food, medical expenses, transportation, and other personal necessities and the presence of other dependent persons in the home. The applicant spouse may apply to the state department for a determination, pursuant to said standards, that the nonapplicant spouse requires a larger portion of the applicant spouse's income or resources and that a smaller portion of the applicant spouse's income or resources will be considered available to the applicant spouse in determining eligibility for medical assistance.

(6) (a) With respect to married couples whose joint income exceeds six hundred percent of the monthly supplemental security income benefit rate established by 42 U.S.C. section 1382 (b) (1), the state department shall have an enforceable right against the nonrecipient spouse for the amount of any medical assistance furnished the applicant spouse pursuant to this article.

(b) Upon the death of a nonrecipient spouse, the state department shall have an enforceable right against the estate of said nonrecipient spouse for the cost of medical care rendered to the recipient spouse under this article.

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

Proposal for Interim Committee
on Long-term Health Care Needs

JOINT RESOLUTION NO. 1

WHEREAS, National demographic projects suggest significant future increases in life expectancy and a large increase in the number of elderly as a percentage of the population; and

WHEREAS, The incidence of chronic illness and the rate of long-term health care utilization increases with age and becomes a major cause of disability requiring medical care; and

WHEREAS, The impact of the aging of the population from 1988 through the year 2000 on the health care system of the United States is projected to significantly increase the days of hospital care required, the total number of physician visits required, and the number of nursing home residents; and

WHEREAS, Expenditures on nursing homes have increased dramatically over the past decade, and nearly one-half of these costs are now borne by the states and the federal government, almost entirely through Medicaid; and

WHEREAS, With government programs under increased pressure, increased attention should be focused on the role of alternative long-term health care financing programs; and

WHEREAS, Individual medical accounts are trusts created or organized to pay the eligible medical, dental, and long-term care expenses of the account holders; and

WHEREAS, Federal incentives would encourage individuals to save money to pay for their own medical, dental, and long-term care expenses and thereby relieve state and federal taxpayers of a portion of the cost they pay for society's medical, dental, and long-term care; now, therefore,

Be It Resolved by the House of Representatives of the Fifty-sixth General Assembly of the State of Colorado, the Senate concurring herein:

That, as an incentive to encourage individuals to plan for their future and to pay for their own health care needs, the Congress of the United States is urged to enact legislation providing a federal income tax deduction for money deposited into an individual medical account.

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

Be It Further Resolved, That copies of this Resolution be sent to the President of the United States, to the President of the Senate and Speaker of the House of Representatives of the Congress of the United States, to the chairman of the Senate Committee on Finance and the chairman of the House Committee on Ways and Means, and to each member of Congress from the State of Colorado.

Interim Committee on
Long-Term Health Care Needs

JOINT RESOLUTION NO. 2

WHEREAS, Financing long-term health care is a significant policy problem that will become more severe as life expectancy and the number of elderly as a percentage of the population increases; and

WHEREAS, The impact of the aging of the population is projected to significantly increase the number of nursing home residents; and

WHEREAS, Expenditures on nursing homes have increased dramatically over the past decade, and nearly one-half of these costs are now borne by the states and the federal government, almost entirely through Medicaid; and

WHEREAS, National studies suggest that the increased use of long-term health care insurance could reduce Medicaid costs; and

WHEREAS, Federal incentives would encourage individuals to take responsibility for their own finances and pay their own long-term care expenses; and

WHEREAS, Long-term health care insurance coverage includes benefits for necessary diagnostic, preventive, therapeutic, rehabilitative, or custodial services rendered in or by a duly licensed nursing care facility, intermediate nursing facility, or home health agency; now therefore,

Be It Resolved by the House of Representatives of the Fifty-sixth General Assembly of the State of Colorado, the Senate concurring herein:

(1) That, as an incentive for individuals to purchase long-term health care insurance, in order to pay for their own health care needs and to possibly reduce future government costs for nursing home care, the Congress of the United States is urged to enact legislation to specifically provide individuals an income tax deduction for long-term health care insurance premiums from federal taxable income or to allow

long-term health care insurance premiums to be included as a medical expense for federal income tax purposes and to lower the current 7.5 percent federal threshold for medical expense deductions from adjusted gross income.

(2) That each member of Congress from the State of Colorado is urged to give full support to such legislation.

Be It Further Resolved, That copies of this Resolution be sent to the President of the United States, to the President of the Senate and Speaker of the House of Representatives of the Congress of the United States, to the chairman of the Senate Committee on Finance and the chairman of the House Committee on Ways and Means, and to each member of Congress from the State of Colorado.

Bill 12

Interim Committee on Long-Term Health Care Needs

A BILL FOR AN ACT

CONCERNING DISABLED ADULTS IN NEED OF PROTECTIVE SERVICES, AND PROVIDING FOR THE DISCOVERY, INVESTIGATION, AND TREATMENT THEREOF, AND MAKING AN APPROPRIATION IN CONNECTION THEREWITH.

Bill Summary

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

Expands the availability of protective services to disabled adults in need thereof. Modifies and expands definitional terms. Limits protective services to those services constituting the least restrictive intervention necessary to remedy the situation. Urges anyone who has knowledge or reasonable basis to believe that a disabled adult is in need of protective services to report such information to a county department of social services. Requires a county department to assess need in each reported case; to prepare a plan for provision of protective services; to take action to supply necessary protection; and to notify licensing authorities of any hospital or care facility of all instances of abuse of a disabled adult occurring at such a facility. Requires the department of social services, in conjunction with county departments, to compile statistical information.

Authorizes the state department to promulgate appropriate rules and regulations.

Makes an appropriation.

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

SECTION 1. Article 3.1 of title 26, Colorado Revised Statutes, 1982 Repl. Vol., as amended is REPEALED AND REENACTED, WITH AMENDMENTS, to read:

ARTICLE 3.1

Disabled Adults in Need of Protective Services

26-3.1-101. Definitions. As used in this article, unless the context otherwise requires:

(1) "Abuse" means the unreasonable confinement or intimidation of, or the infliction of physical pain or injury upon, including the causing of involuntary sexual relations upon, a disabled adult; and "abuse" also means the failure of such disabled adult's caretaker to reasonably prevent the same.

(2) "Caretaker" means an individual, facility, or other entity which has responsibility, as the result of a family relationship or a legal relationship, or which has assumed responsibility for the care of a disabled adult.

(3) "Disabled adult" means a person eighteen years of age or older who is physically or mentally disabled to the extent that he cannot prevent the abuse, neglect, or exploitation of himself and has no one else to act on his behalf.

(4) "Exploitation" means the illegal or improper use of a disabled adult or his resources for another person's profit or advantage.

(5) "Facility" means any hospital, nursing facility,

personal care boarding home, residential facility, or other entity required to be licensed or certified by the state of Colorado.

(6) "Lacks capacity to consent" means, in reference to a disabled adult, that he lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person or property because of a physical or mental incapacity.

(7) "Least restrictive intervention" means the acquiring or providing of services, including protective services, for the shortest duration and in the least quantity necessary to remedy situations of actual or potential abuse, neglect, or exploitation.

(8) "Neglect" means an act or failure to act whereby a disabled adult is placed in imminent danger because such adult or his caretaker is unable to secure, or has not provided, those services which are necessary to maintain the health of such adult.

(9) "Protective services" means the acceptance of reports, the investigation of reports, the assessment of the need for services, the development of service plans, and the arrangement for such services as may be appropriate and available.

26-3.1-102. Action upon receipt of report. The county department shall initiate an assessment of each reported case of abuse, neglect, or exploitation of a disabled adult. In instances where the circumstances surrounding a report

indicate that said adult is actually, or likely to be, in a dangerous or life-threatening situation, the county department shall initiate an assessment on the day that the case is reported. In other instances, the county department shall initiate an assessment within three working days. All assessments shall be documented and kept on file in the county department.

26-3.1-103. Provision of protective services with consent. (1) If, after assessment, the county department determines that a disabled adult is being abused, neglected, or exploited or that there is an imminent risk of the same and if such an adult consents to the provision of protective services, the county department shall provide or arrange for the provision of protective services.

(2) The county department shall prepare a service plan for a disabled adult which coordinates services with other public or private agencies which may provide needed services. If the disabled adult is an identified client of another state agency, services shall be coordinated in conjunction with said agency. For the purposes of this section, a "service plan" is a detailed outline describing those services to be provided to meet the needs of a disabled adult.

26-3.1-104. Provision of protective services without consent. Except as provided in section 26-3.1-109, if a disabled adult who is being abused, neglected, or exploited does not consent to the provision of protective services and the county department reasonably determines that such adult

lacks capacity to consent, is a danger to himself or others, or is in imminent danger of irreparable harm or death and that there is no one else willing or competent to provide services or to petition the court, the county department shall petition the court pursuant to part 3 of article 14 of title 15, C.R.S., for an order authorizing the provision of specific protective services and for the appointment of a guardian; for an order authorizing the appointment of a conservator pursuant to part 4 of article 14 of title 15, C.R.S.; for a seventy-two-hour treatment and evaluation pursuant to section 27-10-105, C.R.S.; or for a court order providing for any combination of these actions.

26-3.1-105. Abuse in a facility or by the facility staff. When the county department finds a case of abuse, neglect, or exploitation perpetrated upon a disabled adult within a facility or by the facility staff, the county department shall report the same to the facility's funding, licensing, and certifying agencies.

26-3.1-106. Report - contents - immunity. (1) (a) The following persons are urged to make or initiate a report of known or suspected abuse, neglect, or exploitation of a disabled adult:

(I) Physicians, surgeons, and osteopaths, including physicians in training;

(II) Medical examiners and coroners;

(III) Optometrists;

(IV) Chiropractors;

(V) Podiatrists;

(VI) Registered nurses and licensed practical nurses;

(VII) Hospital and nursing home personnel engaged in the admission, care, or treatment of patients;

(VIII) Christian science practitioners;

(IX) Physical therapists;

(X) Psychologists and other mental health professionals;

(XI) Social work practitioners;

(XII) Dentists;

(XIII) Law enforcement officials;

(XIV) Attorneys;

(XV) Fire protection personnel;

(XVI) Clergy;

(XVII) Homemakers; and

(XVIII) Personal care providers.

(b) If any other person observes or has reasonable cause to know or suspect that a disabled adult is or has been subjected to abuse, neglect, or exploitation or is subject to circumstances or conditions which would reasonably result in such abuse, neglect, or exploitation or that such an adult constitutes a danger to himself or is believed to be endangering the health and safety of others, such person is also urged to report immediately or cause a report to be made to the county department.

(2) The report shall include: The name and address of the disabled adult; the name and address of his caretaker, if any; the age, if known, of such an adult; the nature and

extent of such an adult's injury or other condition resulting from abuse, neglect, or exploitation; and any other pertinent information.

(3) Anyone who makes a report pursuant to this section shall be immune from any civil or criminal liability on account of such report or testimony if such person acted in good faith and without malice in making such report.

26-3.1-107. County coordinating task force. (1) Each county department is urged to establish a coordinating task force consisting of representatives in the areas of health, social services, mental health, developmental disabilities, law enforcement, the judiciary, and other public and private agencies having some responsibility or capacity for providing services to adults in need of protective services. Any county department may establish a coordinating task force either alone or in conjunction with any neighboring county or counties.

(2) The role of the task force shall include encouraging cooperation among participating agencies, case consultation, and educating the public on the issues of adult protection.

26-3.1-108. Responsibilities of the state department and the county departments. (1) The several county departments shall maintain case records and shall gather statistical information as required by the state department pursuant to subsection (2) of this section.

(2) The state department shall compile statistics obtained from the several county departments, which shall

include: The number of cases of disabled adults in need of protective services reported for assessment, categorized by age and sex; the number of substantiated cases, categorized by type; the number of unsubstantiated cases; the number of cases in which disabled adults in need of protective services voluntarily accepted services; the number of cases in which a county department petitioned a court for guardianship or for a protective order.

(3) The state department shall prepare a written report semiannually of the statistics gathered pursuant to subsection (2) of this section and shall make said report available upon request.

(4) The state department shall provide training and technical assistance to county departments.

26-3.1-109. Limitation. Nothing in this article shall be construed to mean that a person is abused, neglected, exploited, or in need of protective services for the sole reason that he is being furnished or relies upon treatment by spiritual means through prayer alone in accordance with the tenets and practices of a recognized church or religious denomination, nor shall anything in this article be construed to authorize, permit, or require any medical care or treatment in contravention of the stated or implied objection of a person being furnished or relying upon such treatment.

26-3.1-110. Least restrictive intervention required. Any protective services provided pursuant to this article shall include only those services constituting the least

restrictive intervention.

26-3.1-111. Rules and regulations. The state board shall promulgate appropriate rules and regulations for the implementation of this article.

SECTION 2. Appropriation. In addition to any other appropriation, there is hereby appropriated, out of any moneys in the general fund not otherwise appropriated, to the department of social services, for the fiscal year beginning July 1, 1988, the sum of _____ ($), or so much thereof as may be necessary, for the implementation of this act.

SECTION 3. Effective date. This act shall take effect October 1, 1988.

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

Bill 13

Interim Committee on
Long-term Health Care Needs

A BILL FOR AN ACT

CONCERNING THE DEVELOPMENT OF A SPECIALIZED TRAINING PROGRAM ON DEMENTING ILLNESSES INCLUDING ALZHEIMER'S DISEASE, AND MAKING AN APPROPRIATION IN CONNECTION THEREWITH.

Bill Summary

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

Directs the department of social services to contract with a provider knowledgeable in the diagnosis, treatment, and care of persons with Alzheimer's disease and other similar dementing illnesses to provide specialized training to designated personnel who will train family members about the disease or illness and, when appropriate, in care-giving to the patient. Authorizes the department of social services to take applications for training from public and private agencies, with an emphasis on training personnel located in the rural areas of the state.

Makes an appropriation to the department of social services to implement the act.

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

SECTION 1. Article 1 of title 26, Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SECTION to read:

26-1-129. Training of personnel on Alzheimer's disease

and other dementing illnesses. The state department shall contract with a provider experienced and knowledgeable in the diagnosis, treatment, and care of persons with Alzheimer's disease and other similar dementing illnesses to provide special training to designated personnel of public or private agencies. The designated personnel shall be trained to provide basic information and guidance to family members of a person with Alzheimer's disease or another similar dementing illness and, when appropriate, to provide training to family members in order to enable them to serve as care-givers. The state department, subject to available appropriations, shall accept applications from any public or private agency which demonstrates the capacity to utilize the training on Alzheimer's disease and other dementing illnesses on a permanent basis. The state department shall provide such training, whenever possible, to personnel located in the rural areas of the state.

SECTION 2. Appropriation. In addition to any other appropriation, there is hereby appropriated, out of any moneys in the general fund not otherwise appropriated, to the department of social services, for the fiscal year beginning July 1, 1988, the sum of twelve thousand dollars ($12,000), or so much thereof as may be necessary, for the implementation of this act.

SECTION 3. Effective date. This act shall take effect July 1, 1988.

SECTION 4. Safety clause. The general assembly hereby

finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Bill 14

Interim Committee on Long-term
Health Care Needs

A BILL FOR AN ACT

CONCERNING THE ESTABLISHMENT OF AN ALZHEIMER'S DISEASE RESPITE CARE PILOT PROGRAM, AND MAKING AN APPROPRIATION IN CONNECTION THEREWITH.

Bill Summary

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

Establishes a pilot program to provide respite care for persons afflicted by Alzheimer's disease and to evaluate several issues associated with Alzheimer's disease respite care. Designates the department of social services to establish and administer the program. Authorizes the acceptance of grants or donations to pay for some or all of the pilot program.

Makes an appropriation to the department of social services.

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

SECTION 1. Part 2 of article 4.5 of title 26, Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SECTION to read:

26-4.5-213. Pilot program for Alzheimer's disease respite care - creation - repeal. (1) The general assembly

hereby finds and declares that a pilot program shall be established by the state department to provide respite care services for persons afflicted by Alzheimer's disease.

(2) Under such a pilot program, projects shall be developed to encourage different models of respite care appropriate for metropolitan, suburban, and rural settings. The program shall also include an evaluation component to determine what aspects of respite care are best suited for enabling the family members of a person afflicted with Alzheimer's disease to act as care providers, to identify what services are appropriate during the different stages of Alzheimer's disease, and to develop a data base for further study of Alzheimer's disease care.

(3) Pursuant to article 4 of title 24, C.R.S., the state department shall adopt rules and regulations for the administration of this section.

(4) The state department may designate any county department to act for it in performing the duties assigned to the state department by this section.

(5) The state department shall contract with an agency having health services evaluation experience for evaluation of the pilot program and shall present a report based on such evaluation to the general assembly not later than January 1, 1990.

(6) The state department is authorized to receive contributions, grants, services, and in-kind donations from private sources and may use such donations to pay for some or

all of direct and indirect costs of the pilot program.

(7) This section is repealed, effective July 1, 1990.

SECTION 2. Appropriation. In addition to any other appropriation, there is hereby appropriated, out of any moneys in the general fund not otherwise appropriated, to the department of social services, for the fiscal year beginning July 1, 1988, the sum of two hundred thousand dollars ($200,000), or so much thereof as may be necessary, for the implementation of this act.

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

Bill 15

Interim Committee on Long-term Health Care Needs
BY REPRESENTATIVE Knox

A BILL FOR AN ACT

CONCERNING THE REQUIREMENTS FOR POLICIES OF LONG-TERM CARE INSURANCE.

Bill Summary

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

States that policies of long-term care insurance which cover Alzheimer's disease, senile dementia, other organic brain syndromes, or other types of senility diseases shall not require the prior hospitalization or nursing home institutionalization of the insured in order to receive coverage for home health care.

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

SECTION 1. 10-19-103, Colorado Revised Statutes, 1987 Repl. Vol., is amended BY THE ADDITION OF A NEW SUBSECTION to read:

10-19-103. Form and content of policy. (3) Those policies of insurance for long-term care which cover Alzheimer's disease, senile dementia, other organic brain syndromes, or other types of senility diseases shall not require the hospitalization or nursing home

institutionalization or both of the insured prior to home health care in order for the insured to receive coverage for home health care.

SECTION 2. Effective date - applicability. This act shall take effect July 1, 1988, and shall apply to policies of insurance issued or renewed on or after such date.

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

Bill 16

Interim Committee on
Long-term Health Care

A BILL FOR AN ACT

CONCERNING THE RIGHT OF PERSONS TO REJECT NOURISHMENT THROUGH MEDICAL PROCEDURE OR INTERVENTION.

Bill Summary

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

Amends the "Colorado Medical Treatment Decision Act" (Living Will Law) to allow an individual to direct in his "living will" that nourishment provided through medical procedure or intervention be withdrawn after a period of thirty or more days, if nourishment is the only life-sustaining procedure being used.

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

SECTION 1. 15-18-103 (7), Colorado Revised Statutes, 1987 Repl. Vol., is amended to read:

15-18-103. Definitions. (7) "Life-sustaining procedure" means any medical procedure or intervention that, if administered to a qualified patient, would serve only to prolong the dying process. "Life-sustaining procedure" shall not include any medical procedure or intervention ~~to--nourish the-qualified-patient-or~~ considered necessary by the attending

physician to provide comfort or alleviate pain.

SECTION 2. 15-18-104 (3), Colorado Revised Statutes, 1987 Repl. Vol., is amended, and said 15-18-104 is further amended BY THE ADDITION OF A NEW SUBSECTION, to read:

15-18-104. Declaration as to medical treatment. (2.5) In the case of a qualified patient for whom the only life-sustaining procedure is nourishment, such life-sustaining procedure may be withdrawn after a period of thirty or more days.

(3) A declaration executed before two witnesses by any competent adult shall be legally effective for the purposes of this article and may, but need not be, in the following form:

DECLARATION AS TO MEDICAL OR SURGICAL TREATMENT

I, (name of declarant), being of sound mind and at least eighteen years of age, direct that my life shall not be artificially prolonged under the circumstances set forth below and hereby declare that:

1. If at any time my attending physician and one other physician certify in writing that:

a. I have an injury, disease, or illness which is not curable or reversible and which, in their judgment, is a terminal condition; and

b. For a period of forty-eight consecutive hours or more, I have been unconscious, comatose, or otherwise incompetent so as to be unable to make or communicate responsible decisions concerning my person; OR FOR A PERIOD OF

THIRTY OR MORE DAYS I HAVE BEEN IN SUCH CONDITION AND THE ONLY LIFE-SUSTAINING PROCEDURE BEING USED IS NOURISHMENT; then

I direct that life-sustaining procedures shall be withdrawn and withheld, it being understood that life-sustaining procedures shall not include any medical procedure or intervention ~~for--nourishment--or~~ considered necessary by the attending physician to provide comfort or alleviate pain.

2. I execute this declaration, as my free and voluntary act, this _____ day of _____, 19____.

By _____
Declarant

The foregoing instrument was signed and declared by _____ to be his declaration, in the presence of us, who, in his presence, in the presence of each other, and at his request, have signed our names below as witnesses, and we declare that, at the time of the execution of this instrument, the declarant, according to our best knowledge and belief, was of sound mind and under no constraint or undue influence.

Dated at _____, Colorado, this _____ day of _____, 19____.

_____
Name and Address

_____
Name and Address

STATE OF COLORADO)
) ss.

County of _____)

SUBSCRIBED and sworn to before me by _____, the declarant, and _____, and _____, witnesses, as the voluntary act and deed of the declarant, this _____ day of _____, 19 ____.

My commission expires:

_____

Notary Public

SECTION 3. 15-18-107, Colorado Revised Statutes, 1987 Repl. Vol., is amended to read:

15-18-107. Withdrawal - withholding of life-sustaining procedures. In the event that an attending physician is presented with an unrevoked declaration executed by a declarant whom the physician believes has a terminal condition, the attending physician shall cause the declarant to be examined by one other physician. If both physicians find that the declarant has a terminal condition, they shall certify such fact in writing and enter such in the qualified patient's medical record of the hospital in which the withholding or withdrawal of life-sustaining procedures may occur, together with a copy of the declaration. If the attending physician has actual knowledge of the whereabouts of the qualified patient's spouse, any of his adult children, a parent, or attorney-in-fact under a durable power of attorney, the attending physician shall immediately make a reasonable

effort to notify at least one of said persons, in the order named, that a certificate of terminal condition has been signed. If no action to challenge the validity of a declaration has been filed within forty-eight consecutive hours after the certification is made by the physicians, OR WITHIN THIRTY DAYS AFTER CERTIFICATION IF THE ONLY LIFE-SUSTAINING PROCEDURE BEING USED IS NOURISHMENT, the attending physician shall then withdraw or withhold all life-sustaining procedures pursuant to the terms of the declaration.

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

Bill 17

Interim Committee on
Long-term Health Care Needs

A BILL FOR AN ACT

CONCERNING THE STATUTES OF LIMITATIONS FOR THE COMMENCEMENT OF CIVIL ACTIONS IN COLORADO, AND IN CONNECTION THEREWITH REINSTATING THE STATUTE OF REPOSE FOR ACTIONS INVOLVING HEALTH CARE AND AMENDING THE DEFINITION OF PERSONS UNDER A DISABILITY AND THE PROVISIONS RELATING TO THE ACCRUAL OF CERTAIN CAUSES OF ACTION.

Bill Summary

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

Reinstates former provisions of the statutes of limitations which were omitted in the omnibus statute of limitations revision bill of the 1986 session. Such provisions include: 1) Reinstating the statute of repose, and the exceptions (knowing concealment and leaving an unauthorized foreign object in the patient's body) and the special provisions for minors thereto, for actions against physicians, hospitals, and other health care providers; and 2) Recognizing a natural guardian (parent) to the same extent as a legal guardian for purposes of defining a "person under disability".

Specifies that a cause of action accrues for injury to person, property, reputation, possession, relationship, or status on the date the injury is discovered or should have been discovered rather than on the date both the injury and its cause are known or should have been known.

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

SECTION 1. 13-80-102 (1) (c), Colorado Revised Statutes, 1987 Repl. Vol., is amended to read:

13-80-102. General limitation of actions - two years - special limitations for actions against health care providers. (1) (c) (I) All actions, regardless of the theory asserted, against any hospital, health care facility, clinic, physician, nurse, dentist, chiropractor, veterinarian, practitioner, therapist, technician, midwife, pharmacist, optometrist, podiatrist, paraprofessional, or other person involved in any of the healing arts; EXCEPT THAT IN NO EVENT MAY SUCH ACTION BE INSTITUTED MORE THAN THREE YEARS AFTER THE ACT OR OMISSION WHICH GAVE RISE THERETO, SUBJECT TO THE FOLLOWING EXCEPTIONS:

(A) IF THE ACT OR OMISSION WHICH GAVE RISE TO THE CAUSE OF ACTION WAS KNOWINGLY CONCEALED BY THE PERSON COMMITTING SUCH ACT OR OMISSION OR IF SUCH ACT OR OMISSION CONSISTED OF LEAVING AN UNAUTHORIZED FOREIGN OBJECT IN THE BODY OF THE PATIENT, THEN SUCH ACTION MAY BE INSTITUTED WITHIN TWO YEARS AFTER THE PERSON BRINGING THE ACTION DISCOVERED, OR IN THE EXERCISE OF REASONABLE DILIGENCE AND CONCERN SHOULD HAVE DISCOVERED, THE ACT OR OMISSION;

(B) IF THE ACTION IS BROUGHT BY OR ON BEHALF OF A MINOR WHO WAS UNDER SIX YEARS OF AGE ON THE DATE OF THE OCCURRENCE OF THE ACT OR OMISSION FOR WHICH SUCH ACTION IS BROUGHT, THEN SUCH ACTION MAY BE INSTITUTED WITHIN TWO YEARS AFTER SAID MINOR REACHES SIX YEARS OF AGE.

(II) THE LIMITATIONS PERIOD PROVIDED FOR IN SUBPARAGRAPH (I) OF THIS PARAGRAPH (c) SHALL NOT RUN DURING ANY PERIOD WHEN THE SAID MINOR IS UNDER THE AGE OF EIGHTEEN YEARS AND HAS NO NATURAL OR LEGAL GUARDIAN. IF THERE IS NO NATURAL OR LEGAL GUARDIAN, SUCH ACTION MAY BE INSTITUTED BY OR ON BEHALF OF SAID MINOR WITHIN TWO YEARS AFTER A LEGAL GUARDIAN IS APPOINTED BY A COURT OF RECORD OR WITHIN TWO YEARS AFTER THE PERSON UNDER DISABILITY REACHES EIGHTEEN YEARS OF AGE, WHICHEVER OCCURS FIRST. IF THERE IS NO NATURAL OR LEGAL GUARDIAN, THE LIMITATIONS PERIOD SHALL NOT RUN UNLESS A GUARDIAN AD LITEM IS APPOINTED TO REPRESENT THE MINOR CHILD.

(III) FOR PURPOSES OF THIS PARAGRAPH (c) ONLY, "PERSON UNDER DISABILITY" MEANS A MINOR UNDER SIX YEARS OF AGE, A PERSON UNDER THE AGE OF EIGHTEEN YEARS WHO DOES NOT HAVE A NATURAL OR LEGAL GUARDIAN, A MENTAL INCOMPETENT, OR A PERSON UNDER ANY OTHER LEGAL DISABILITY.

SECTION 2. 13-80-108 (1), Colorado Revised Statutes, 1987 Repl. Vol., is amended to read:

13-80-108. When a cause of action accrues. (1) (a) EXCEPT AS PROVIDED IN PARAGRAPH (b) OF THIS SUBSECTION (1), a cause of action for injury to person, property, reputation, possession, relationship, or status shall be considered to accrue on the date both the injury and ~~its--cause~~ THE FACT THAT IT WAS NEGLIGENTLY CAUSED BY THE ACTS OF ANOTHER are known or should have been known by the exercise of reasonable diligence.

(b) A CAUSE OF ACTION FOR INJURY TO PERSON BROUGHT UNDER

SECTION 13-80-102 (1) (c) SHALL BE CONSIDERED TO ACCRUE ON THE DATE THE INJURY IS DISCOVERED OR SHOULD HAVE BEEN DISCOVERED BY THE EXERCISE OF REASONABLE DILIGENCE AND CONCERN.

SECTION 3. 13-81-101 (3), Colorado Revised Statutes, 1987 Repl. Vol., is amended to read:

13-81-101. Definitions. (3) EXCEPT AS PROVIDED IN SECTION 13-80-102 (1) (c), "person under disability" means any person who is a minor under eighteen years of age, a mental incompetent, or a person under other legal disability and who does not have a NATURAL OR legal guardian.

SECTION 4. Effective date - applicability. This act shall take effect July 1, 1988, and shall apply to acts or omissions occurring on or after said date.

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

Bill 18

Interim Committee on Long-term Health Care Needs

A BILL FOR AN ACT

CONCERNING PERIODIC PAYMENTS OF TORT JUDGMENTS IN CIVIL ACTIONS AGAINST HEALTH CARE PROVIDERS AND HEALTH 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.)

Requires the trial judge to enter a judgment ordering that future damages in civil actions brought against any health care provider or health care institution be paid by periodic payments rather than a lump sum payment for awards exceeding a specific amount. Requires the trier of fact to make specific findings relating to the periodic payments and the amount of damages. Specifies the procedures for determining the judgment to be entered. States that money damages awarded for loss of future earnings shall not be reduced or terminated by the death of the judgment creditor.

Requires the court to approve the method of funding of the periodic payment. Specifies the procedures if a person fails to fund the periodic payment. Clarifies when a right to receive periodic payment may be assigned. Exempts periodic payments for future damages from garnishment, attachment, and other similar claims. States that this act does not limit or affect settlement agreements or consent judgments. Allows the court to order a satisfaction of judgment and discharge of the judgment creditor under certain circumstances.

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

SECTION 1. Title 13, Colorado Revised Statutes, 1987

Repl. Vol., is amended BY THE ADDITION OF A NEW ARTICLE to read:

ARTICLE 64

Periodic Payments of Tort Judgments

13-64-101. Legislative declaration. (1) The general assembly declares the purposes of enacting this article are to:

(a) Alleviate the practical problems incident to the unpredictability of future losses;

(b) Effectuate more precise awards of damages for actual losses;

(c) Pay damages as the losses are found to accrue;

(d) Assure that payments of damages more nearly serve the purposes for which they are awarded;

(e) Reduce the burden on public assistance costs created by the dissipation of lump-sum payments; and

(f) Conform to the income tax policies in the United States internal revenue code and the laws of this state with respect to compensation for personal injuries.

13-64-102. Definitions. As used in this article, unless the context otherwise requires:

(1) "Economic loss" means pecuniary harm for which damages are recoverable under the laws of this state.

(2) "Future damages" means damages of any kind arising from personal injuries which the trier of fact finds will accrue after the damages findings are made.

(3) "Health care institution" means any licensed or

certified hospital, health care facility, dispensary, or other institution for the treatment or care of the sick or injured.

(4) "Health care professional" means any person licensed in this state or any other state to practice medicine, chiropractic, nursing, physical therapy, podiatry, dentistry, pharmacy, optometry, or other healing arts.

(5) "Noneconomic loss" means nonpecuniary harm for which damages are recoverable under the laws of this state, but the term does not include punitive or exemplary damages.

(6) "Past damages" means damages that have accrued when the damages findings are made, including any punitive or exemplary damages allowed by the laws of this state.

(7) "Qualified insurer" means an insurance company licensed to do business in this state, or any self-insurer, assignee, plan, or arrangement approved by the court.

13-64-103. Periodic payments. (1) (a) In any civil action for damages in tort brought against a health care professional or a health care institution, the trial judge shall enter a judgment ordering that awards for future damages be paid by periodic payments rather than by a lump-sum payment if the award equals or exceeds the present value of one hundred thousand dollars, as determined by the court.

(b) In any such action in which the award is less than one hundred thousand dollars, the trial judge may order that awards for future damages be paid by periodic payments.

13-64-104. Special damages findings required. (1) (a) If liability is found in a trial under this article,

the trier of fact, in addition to other appropriate findings, shall make separate findings for each claimant specifying the amount of:

(I) Any past damages; and

(II) Any future damages and the duration over which they will accrue, on an annual basis, for each of the following types:

(A) Medical and other costs of health care, and other economic loss except loss of future earnings which would be incurred for the life of the claimant or any lesser period;

(B) Loss of future earnings which would be incurred for the work life expectancy of the claimant or a lesser period; and

(C) Noneconomic loss which would be incurred for the life of the claimant or any lesser period.

(2) The calculation of all future damages under sub-subparagraphs (A) and (C) of subparagraph (II) of subsection (1) of this section shall reflect the costs and losses during the period of time, including life expectancy, if appropriate, that the claimant will sustain those costs and losses. The calculation of loss under sub-subparagraph (B) of subparagraph (II) of subsection (1) of this section shall be based on loss during the period of time the claimant would have earned income but for the injury upon which the claim is based.

13-64-105. Determination of judgment to be entered. (1) In order to determine what judgment is to be entered on a

verdict requiring findings of special damages under this article, the court shall proceed as follows:

(a) The court shall apply to the findings of past and future damages any applicable rules of law, including setoffs, credits, comparative fault, additurs, and remittiturs in calculating the respective amounts of past and future damages each claimant is entitled to recover and each party is obligated to pay. The court shall preserve the rights of any subrogee to be paid in a lump sum.

(b) The judgment shall specify the payment of attorney fees and litigation expenses in a manner separate from the periodic installments payable to the claimant, either in a lump sum or by periodic installments, pursuant to any agreement entered into between the claimant or beneficiary and his attorney, computed in accordance with the applicable principles of law.

(c) The court shall enter judgment in a lump sum for past damages and for any damages payable in lump sum or otherwise under paragraphs (a) and (b) of this subsection (1).

(d) The court, after hearing relevant expert testimony, if appropriate, shall enter judgment for the periodic payment of future damages.

(e) Upon petition of a party before entry of judgment and a finding of incapacity to pay the periodic payments, the court, at the election of the claimant or at the election of the beneficiaries in an action for wrongful death, shall enter a judgment for the present value of the periodic payments.

13-64-106. Periodic installment obligations. (1) A judgment for periodic payments under this article shall provide that:

(a) Such periodic payments are fixed and determinable as to amount and time of payment;

(b) Such periodic payments cannot be accelerated, deferred, increased, or decreased by the recipient of such payments; and

(c) The recipient of such payments shall be a general creditor of the qualified insurer.

(2) Unless the court directs otherwise and the parties otherwise agree, payments shall be scheduled at one-month intervals. Payments for damages accruing during the scheduled intervals are due at the beginning of the intervals. The court may direct that periodic payments shall continue for an initial term of years notwithstanding the death of the judgment creditor during that term.

(3) Money damages awarded for loss of future earnings shall not be reduced or payments terminated by reason of the death of the judgment creditor.

13-64-107. Form of funding. (1) A judgment for periodic payments entered in accordance with this article shall provide for payments to be funded in one or more of the following forms approved by the court:

(a) Annuity contract issued by a company licensed to do business as an insurance company under the laws of this state;

(b) An obligation or obligations of the United States;

(c) Evidence of applicable and collectible liability insurance from one or more qualified insurers;

(d) An agreement by one or more personal injury liability assignees to assume the obligation of the judgment debtor; or

(e) Any other satisfactory form of funding.

13-64-108. Funding the obligation. (1) If the court enters a judgment for periodic payments under this article, then each party liable for all or a portion of the judgment, unless found to be incapable of doing so, shall separately or jointly with one or more others provide the funding for the periodic payments in a form prescribed in section 13-64-107, within sixty days after the date the judgment is entered. A liability insurer having a contractual obligation and any other person adjudged to have an obligation to pay all or part of a judgment for periodic payments on behalf of a judgment debtor is obligated to provide such funding to the extent of its contractual or adjudged obligation if the judgment debtor has not done so.

(2) A judgment creditor or successor in interest and any party having rights under subsection (4) of this section may move that the court find that funding has not been provided with regard to a judgment obligation owing to the moving party. Upon so finding, the court shall order that funding complying with this article be provided within thirty days. If funding is not provided within that time and subsection (3) of this section does not apply, then the court shall calculate

the lump-sum equivalent of the periodic payment obligation and enter a judgment for that amount in favor of the moving party.

(3) If a judgment debtor who is the only person liable for a portion of a judgment for periodic payments fails to provide funding, then the right to lump-sum payment described in subsection (2) of this section applies only against that judgment debtor and the portion of the judgment so owed.

(4) If more than one party is liable for all or a portion of a judgment requiring funding under this article and the required funding is provided by one or more but fewer than all of the parties liable, the funding requirements are satisfied and those providing funding may proceed under subsection (2) of this section to enforce rights for funding or lump-sum payment to satisfy or protect rights of reimbursement from a party not providing funding.

13-64-109. Assignment of periodic payments. (1) An assignment by a judgment creditor or an agreement by such person to assign any right to receive periodic payments for future damages contained in a judgment entered under this article is enforceable only as to amounts:

(a) To secure payment of alimony, maintenance, or child support;

(b) For the costs of products, services, or accommodations provided or to be provided by the assignee for medical or other health care; or

(c) For attorney fees and other expenses of litigation incurred in securing the judgment.

13-64-110. Exemption of benefits. Except as provided in section 13-64-109, periodic payments for future damages contained in a judgment entered under this article for loss of earnings are exempt from garnishment, attachment, execution, and any other process or claim to the extent that wages or earnings are exempt.

13-64-111. Settlement agreements and consent judgments. Nothing in this article is to be construed to limit or affect the settlement of actions triable under this article. Parties to an action on a claim for personal injury may, but are not required to, file with the clerk of the court in which the action is pending or, if none is pending, with the clerk of a court of competent jurisdiction over the claim, a settlement agreement for future damages payable in periodic payments. The settlement agreement may provide that one or more sections of this article apply to it.

13-64-112. Satisfaction of judgment. Upon entry of an order by the court that the form of funding complies with section 13-64-107 and that the funding of the obligation complies with section 13-64-108, the court shall order a satisfaction of judgment and discharge of the judgment debtor.

SECTION 2. Effective date. This act shall take effect July 1, 1988.

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

Bill 19

Interim Committee on Long-term Health Care Needs.

A BILL FOR AN ACT

CONCERNING PROTECTIONS FOR QUALITY MANAGEMENT FUNCTIONS OF HEALTH CARE FACILITIES.

Bill Summary

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

Declares that quality management systems to improve patient and resident care are essential to the operation of licensed health care facilities. Provides confidentiality for quality management information and qualified immunity for persons providing reports or participating in quality management functions.

Provides an exception from the confidentiality provisions for a regulatory agency which is authorized by law to make inspections or investigations.

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

SECTION 1. Article 43.5 of title 12, Colorado Revised Statutes, 1985 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SECTION to read:

12-43.5-104. Quality management functions - confidentiality and immunity. (1) The general assembly hereby finds and declares that the implementation of quality

management functions to evaluate and improve patient and resident care is essential to the operation of health care facilities licensed or certified by the department of health pursuant to section 25-1-107 (1) (l), C.R.S. For this purpose, it is necessary that the collection of information and data be unfettered so a complete and thorough evaluation and improvement of the quality of patient and resident care can be accomplished. To this end, quality management information relating to the evaluation or improvement of the quality of health care services shall be confidential and persons performing such functions shall be granted qualified immunity.

(2) For purposes of this section, a "quality management program" means a program which includes quality assurance and risk management activities, the peer review of licensed health care professionals, and other quality management functions which are described and filed with the department of health.

(3) Any records, reports, or other information of a licensed or certified health care facility which are part of a quality management program designed to identify, evaluate, and reduce the risk of patient or resident injury associated with care or to improve the quality of patient care shall be confidential information; except that such information shall be subject to any right of inspection or investigation by the department of health or other appropriate regulatory agency as otherwise provided by law.

(4) The records, reports, and other information

described in subsection (3) of this section shall not be subject to subpoena or discoverable or admissible as evidence in any civil or administrative proceeding. No person who participates in the reporting, collection, evaluation, or use of such quality management information, including any employee of a regulatory agency, shall be permitted or required to testify thereon in any civil or administrative proceeding. However, this subsection (4) shall not apply to:

(a) Any civil or administrative proceeding, inspection, or investigation by the department of health or other appropriate regulatory agency having jurisdiction for disciplinary or licensing sanctions;

(b) Persons giving testimony concerning facts of which they have personal knowledge acquired independently of the quality management information or the evaluation of such information;

(c) The availability, as provided by law or the rules of civil procedure, of information relating solely to the individual in interest in a civil suit by such person.

(5) Any person who participates in the reporting, collection, evaluation, or use of quality management information or performs other functions as part of a quality management program shall be immune from suit in any civil action based on such functions brought by a health care provider or individual who is the subject of quality management information if such person participates in good faith and within the scope of the functions of such quality

management program.

(6) Nothing in this section shall be construed to limit any statutory or common law privilege, confidentiality, or immunity.

SECTION 2. 24-72-204 (3) (a), Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SUBPARAGRAPH to read:

24-72-204. Allowance or denial of inspection - grounds - procedure - appeal. (3) (a) (IX) (A) Any quality management records, reports, or other information described in section 12-43.5-104, C.R.S., of a health care facility licensed or certified by the department of health. Nothing in this subparagraph (IX) shall limit the department of health or another agency from: Disclosing that it has obtained a report concerning quality management information or that an investigation is pending; disclosing information to a regulatory agency having jurisdiction to investigate the information, however, such information disclosed to a regulatory agency shall remain confidential; or releasing a summary report of an agency's findings after an investigation is completed or the agency determines no investigation is warranted. A licensing agency may also release a summary report, notwithstanding a pending investigation, if it determines that such release is necessary for the immediate protection of the public health and safety.

(B) Only a licensing agency may issue a summary report. Prior to releasing a summary report which contains information

identifying a health care facility or licensed health care professional, the licensing agency shall notify the health care facility and professional, and the facility or professional shall be allowed a reasonable time to comment. If immediate release of information is necessary and prior oral notification cannot be given, notification shall be given as soon as reasonably possible and shall state why prior notice could not be given.

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