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Recent Changes in Health Policy for Low-Income People in Colorado

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Further expansions of public sector health care programs do not appear likely because the governor supports private sector expansions and the state has constitutional limits on revenues and public expenditures.

Overview

Colorado policymakers have taken advantage of some of the opportunities available under federal-state programs, particularly Medicaid and the State Children's Health Insurance Program, to piece together a safety net for people with low incomes who lack private health coverage. In addition, the state has used regulation of the small group health insurance market to try to ensure affordability and accessibility of these policies.

Nonetheless, the state's safety net is strained for several reasons. First, Colorado, like many other states with a healthy economy during the late 1990s, began facing an economic slowdown in 2001 that was exacerbated by the reaction to the attacks on September 11, 2001; the slowdown is projected to reduce state revenues. Second, the state's constitutional limits on revenues and on increases in most forms of public sector spending force an annual examination of health care programs for ways to contain costs. For example, state officials project that Medicaid expenditures will grow by 9 to 10 percent a year, which could "crowd out" other programs.

In response to Medicaid cost growth, the state has, over the last few years, used several mechanisms to contain cost increases. The principal mechanism is the reliance on managed care plans to deliver services to Medicaid beneficiaries. Most beneficiaries receive their health care through health maintenance organizations or the Primary Care Physician Program (i.e., primary care case management program), which are designed to contain Medicaid cost growth and improve access to services. The state has also taken steps to reduce certain payments to providers. For example, in state fiscal year 2002, the state reduced some facility and pharmacy fees.

In the face of the constitutional limits, policymakers have undertaken only one major initiative since 1998—implementing the Children's Basic Health Plan. The Children's Basic Health Plan largely relies on managed care plans to deliver services to children through age 18 with family incomes up to 185 percent of the federal poverty level. After significant outreach and enrollment efforts, about half of the estimated 70,000 eligible children have joined the program. In addition, tobacco settlement funds have been used to fund such efforts as a nurse visitor program for mothers with infants and home and community services for the older population. The state has no plans to provide coverage of pharmaceuticals for Medicare beneficiaries, with the governor believing that this coverage should come from the federal government.

Another part of the safety net—the state's indigent care programs—is funded primarily through maximization of disproportionate share hospital (DSH) payments under Medicaid. Most of these funds go to nine hospitals, which operate primarily in the Denver metropolitan area. This portion of the safety net is under significant pres-

sure because these reimbursements are low for some providers and because availability of indigent care is sparse outside of the Denver metropolitan area.

Despite the pressures on the safety net, major expansions in public health insurance coverage are not likely because of the constitutional limits described above and due to Governor Owens' strong preference for relying on the private sector to expand health care coverage. Employer-sponsored health insurance plays a larger role in covering Colorado's low-income population than in most other states, perhaps because of the state's extremely tight labor market. In such a market, employers may be more likely to offer health insurance to recruit and retain employees. However, the recent downturn in the state's economy may erode private health care coverage.

Colorado was one of the first states to use a single-point-of-entry system to assess need and determine what setting would be most appropriate for aged or disabled applicants if they qualify for Medicaid long-term care services. The system serves as the entry point for nursing home care as well as home and community services. The Medicaid program has a large waiver that provides home and community services to this population as well as an innovative state-funded, consumer-directed program that provides a cash allowance to people with disabilities who then hire and fire their own personal care workers.

Colorado relies on managed care organizations to serve those with mental health conditions or developmental disabilities. The Medicaid population that needs long-term mental health services receives them through the Medicaid Mental Health Capitation and Managed Care Program, which gives eight local Mental Health Assessment and Services Agencies responsibility for providing or arranging for mental health services for beneficiaries. Twenty community-centered boards serve as the single entry point to the publicly funded support system for persons with developmental disabilities; these boards determine eligibility and arrange for and monitor an individually tailored set of services for each beneficiary.

Labor shortages among long-term care providers have caused the state to raise certain providers' rates and state officials to be concerned about the quality of care, particularly in the home and community, if labor shortages continue.

The Supreme Court's *Olmstead* decision, which affirms a limited right to home and community services for the population with disabilities under certain circumstances, appears to be of most concern in programs serving those with mental health conditions. The systems serving the aged and those with physical or developmental disabilities are less likely to be affected by this decision because these systems already serve a relatively high percentage of beneficiaries in the home and community.

These findings about changes in Colorado's health care system build upon a previous case study conducted in 1997.[1] The purpose of this second study is to examine how Colorado and other states have responded to both federal constraints and state flexibility since the late 1990s. Constraints have included funding limitations such as restrictions on the use of the Medicaid disproportionate share hospital and upper payment limit strategies. Flexibility has included expanded use of Medicaid waivers and the availability of new funding such as the State Children's Health Insurance Program. To conduct a comprehensive examination of Colorado's reactions to the constraints and flexibility, we explored five topics. First, how have the political and fiscal circumstances of the state changed over the last several years? Second, how has the state changed its public or private health insurance coverage? Third, how have Medicaid managed care and other acute care issues changed? Fourth, how are states responding to pressures to expand home- and community-based services for persons with disabilities? Fifth, what other issues were prominent? Information contained in this Colorado site visit report comes from interviews conducted in the summer of 2001, a literature review, and reports available from the state.

TABLE 1. Selected Colorado Characteristics

	Colorado	United States
Population Characteristics		
Population (2000) (in thousands)[a]	4,301	281,422
Percent under age 18 (1999)[a]	25.3%	25.7%
Percent Hispanic (1999)[b]	15.6%	12.5%
Percent black (1999)[b]	4.1%	12.8%
Percent Asian (1999)[b]	3.7%	4.1%
Percent nonmetropolitan (1999)[b]	17.2%	20.3%
State Economic Characteristics		
Per capita income (2000)[c]	$32,949	$29,676
Percent change per capita income (1995–1999)[d]	16.0%	10.8%
Unemployment rate (2001)[e]	2.7%	4.5%
Family Profile		
Percent children in poverty (1998)[f]	12.3%	17.5%
Percent change children in poverty (1996–1998)[f]	–16.3%	–15.0%
Percent adults in poverty (1998)[f]	9.0%	11.2%
Percent change adults in poverty (1996–1998)[f]	–11.8%	–10.4%
Political		
Governor's affiliation (2001)[g]	Republican	NA
Party composition of senate (2001)[h]	18D-17R	NA
Party composition of house (2001)[h]	27D-38R	NA
Percent of Poor Children Covered by Welfare		
1996 (AFDC)[i]	44.4%	59.3%
1998 (TANF)[i]	32.7%	49.9%
Income Cutoff for Children's Eligibility for Medicaid/State Children's Health Insurance Program (Percent of Federal Poverty Level)		
1996[j,k]	94%	124%
1998[j,l]	185%	178%
2000[j,m]	185%	205%

Table 1 notes begin on page 20.

Background

Demographics and Insurance Coverage

Colorado is a fairly large, wealthy state with few metropolitan areas outside of Denver (see table 1). The economy was strong at the time of the site visit with per capita income above the national figure in 2000; growth in per capita income also exceeded the national rate between 1995 and 1999. In addition, unemployment rates were very low. A lower proportion of adults and children lived in poverty in Colorado than in the nation, and the state has proportionately more Hispanics and fewer African Americans than the nation as a whole.

Employer-sponsored health insurance plays a larger role in health care coverage for Colorado's low-income population than in the rest of the country (see table 2). About half of all children and half of adults age 19 to 64 in Colorado living below 200 percent of the federal poverty level relied on employer-sponsored coverage in 1999. According to the Colorado Division of Insurance, about 540,000 people in Colorado had group health insurance through 70,000 small employers, including 29,000 business groups of one (i.e., a self-employed individual) in 2000.[2] About 25,000 small group employees received their coverage through purchasing cooperatives.

TABLE 2. Health Insurance Coverage, by Family Income and Type of Insurance, Colorado and the United States, 1999

	Children (Ages 0–18)[a] (%)		Adults (Ages 19–64)[b] (%)	
	Colorado	**United States**	**Colorado**	**United States**
Below 200% FPL				
Employer-sponsored	**45.5**	38.7	**46.4**	41.7
Medicaid/SCHIP/state	**26.8**	35.2	**6.4**	14.7
Other coverage	4.8	3.8	**16.4**	8.8
Uninsured	**22.9**	22.4	32.6	34.9
Above 200% FPL				
Employer-sponsored	85.3	85.3	**81.0**	83.7
Medicaid/SCHIP/state	**2.6**	3.8	0.7	1.1
Other coverage	**6.8**	4.9	**9.2**	5.8
Uninsured	5.3	6.0	9.2	9.4
All Incomes				
Employer-sponsored	**72.1**	66.7	73.7	72.3
Medicaid/SCHIP/state	**10.7**	16.4	**1.9**	4.8
Other coverage	**6.1**	4.5	**10.3**	6.6
Uninsured	11.1	12.5	**14.1**	16.3

a. Kenney, Genevieve, Lisa Dubay, and Jennifer Haley. 2000. "Health Insurance, Access, and Health Status of Children." In *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families.* Washington, D.C.: The Urban Institute.
b. Zuckerman, Stephen, Jennifer Haley, and John Holahan. 2000. "Health Insurance, Access, and Health Status of Adults." In *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families.* Washington, D.C.: The Urban Institute.

Notes: Figures in bold represent values that are statistically significantly different from the national average at the 0.10 confidence level or better.
FPL = federal poverty level
SCHIP = State Children's Health Insurance Program

Publicly funded sources financed health care for about one-quarter of the state's low-income children and about 6 percent of low-income adults, a lower percentage than in the rest of the United States. Colorado's uninsurance rates are about the same as national rates in most demographic categories.

Political Developments

Although Colorado is a conservative state, Bill Owens was the first Republican to be elected governor in Colorado in 28 years; his four-year term began in 1999. He succeeded former Governor Roy Romer, a three-term Democrat, whose priorities had included the expansion of children's health programs. At the time of the site visit, Republicans controlled the house, and Democrats narrowly controlled the senate.

Health care does not appear to be a prominent issue on Governor Owens's agenda, taking a back seat to public education initiatives. The governor does not want to expand public programs to cover the uninsured. Rather, he wants to focus reform efforts on private sector solutions such as vouchers or tax credits to help the uninsured buy insurance. The governor also does not advocate providing pharmaceutical benefits to Medicare beneficiaries through a publicly funded state program because he believes such coverage should come from the federal government.

Governor Owens has, however, addressed several health care issues. The State Children's Health Insurance Program (SCHIP) was improved by making enrollment in the program easier. In addition, the governor brought the SCHIP board under Medicaid to improve communication between the two programs and agreed to use tobacco settlement funds to add a dental benefit to SCHIP. The governor has expressed interest in modifica-

tions to established publicly funded health care programs. For example, Oregon's approach of setting priorities for coverage of services under Medicaid is one option likely to be considered as a cost containment mechanism. The major health care issue during the 1999 and 2000 legislative sessions was how to allocate tobacco settlement funds. Governor Owens agreed with the legislature that funding be devoted to children's and public health initiatives but wanted a significant portion of funds to go toward education. The compromise was to establish a state trust fund that allocated money to both health and education programs.

Among the most contentious health care issues in the 2001 legislative session was the small group insurance "reforms" that health insurers advocated. The proposals would have weakened the state's community rating for parts of this market and the provider network adequacy requirements. The final legislation made only minor modifications to regulation of the small group market.

Another recent health care development is the state's receipt of a $1.3 million grant from the federal Health Resources and Services Administration to develop a plan for covering the uninsured. The funding will be used to conduct a survey of 10,000 households, which will provide demographic and employment information on the uninsured by county, and to develop policy options for coverage.

The Colorado Coalition for the Medically Underserved was instrumental in obtaining the federal grant. The Coalition, which began in 1997 and is composed of 48 groups representing a wide array of interests,[3] intends to push for coverage of an estimated 700,000 uninsured state residents by 2007. Beginning in 2000, the coalition held town meetings across the state and gained the reactions of over 1,000 attendees to various proposals to provide coverage. Based on these reactions, the Coalition is developing one proposal that will be vetted in additional town hall meetings.

Fiscal Circumstances of the State

Colorado faces a unique fiscal situation in that it has had constitutional limits on tax revenues and most public expenditures since 1991. The Taxpayer's Bill of Rights (TABOR) limits the state's revenue growth in the current year to inflation plus population growth in the previous year. State-funded public expenditures, with the exception of capital improvements such as new roads and prisons, are limited to 6 percent growth a year with no adjustment for inflation or population growth. Although earlier projections for state fiscal year (SFY) 2002 indicated that allowable state revenues would exceed allowable state spending by about $253 million, state officials say that these projections are being revised downward because of increased expenditures and a slowing economy. Currently, state officials anticipate a $170 million shortfall in SFY 2002.

Regardless of the state of the economy, these constitutional limits have had profound effects on efforts to improve or expand publicly funded health programs. These programs are in competition with one another and with other programs for funds, and the pressures to contain Medicaid costs in particular are strong. Major public program expansions appear to be out of the question politically and financially, unless the state's constitution is amended, which would require a statewide referendum.

The state's total operating budget for SFY 2002 including funds from federal sources is $13 billion, up from roughly $9 billion in SFY 1998.[4] Human services and health care absorb 33 percent of the budget, education 34 percent, and corrections 15 percent. Two departments manage health and human services: the Department of Health Care Policy and Financing (DHCPF), which is the lead Medicaid agency and has a budget of $2.5 billion for SFY 2002, and the Department of Human Services (DHS), which manages child welfare programs and services for those with mental health conditions and developmental disabilities, among others, and has a budget of $1.8 billion for SFY 2002. These budgets represent an increase of 32 percent and 29 percent, respectively, over the SFY 1999 budgets. Federal funds play a large role in both departments' budgets, with federal sources supporting about half of the DHCPF budget and one-third of the DHS budget.

Another source of health care funding is the $2.69 billion that Colorado will receive over the next 25 years from the national tobacco settlement. In May 2000, Colorado passed legislation setting out its priorities for use of these funds in SFY 2001.[5] The priorities include the Nurse Home visitor program for mothers with infants, the Children's Basic Health Plan, tobacco-related activities, primary and preventive care, and literacy programs.

Medicaid Trends and Budgetary Prospects

Medicaid enrollment and expenditures have increased substantially since the last site visit and, as a result, the budget is under stress. In SFY 2002, about half of the state's 304,508 Medicaid eligibles were children, 12 percent were nondisabled adults, 16 percent were blind or disabled adults, and 17 percent were age 65 and over.[6] The total number of Medicaid eligibles is expected to increase by about 45,000 from SFY 1999 to SFY 2002. The groups that are projected to contribute most to this growth are children, whose enrollment is expected to increase by 22 percent, and noncitizens, whose enrollment is expected to increase by 158 percent to reach 6 percent of Medicaid eligibles in SFY 2002.

Although Medicaid eligibility standards will not change a great deal in SFY 2002, the Colorado DHCPF and DHS are jointly developing the Colorado Benefits Management System to simplify the eligibility determination process for public benefits. This computerized application system will allow people the opportunity to apply for the entire spectrum of public benefit programs with one application form and one interview.[7]

Colorado will spend $2.3 billion on Medicaid (state and federal spending) in SFY 2002, including $923.5 million for acute services, $631.7 million for long-term care services, and $512.7 million for mental health and developmental disability services.[8] Colorado's total Medicaid expenditures grew quite rapidly at an average annual rate of 7.7 percent from 1995 to 1998, much higher than the national rate of 3.9 percent (see table 3). (Data from 1998 were the most recent available that offer the opportunity to compare Colorado's Medicaid expenditures to those of the nation.) Medicaid expenditures, excluding those for the Department of Human Services, grew 10.6 percent in SFY 2000—the first double-digit increase in four years—but the figure is projected to be 7.6 percent in SFY 2001.[9]

Reflecting the state's increasing reliance on managed health care plans, Medicaid managed health care expenditures grew 86 percent from SFY 1997 to SFY 2000.[10] Home and community services expenditures grew 80 percent. In contrast, expenditures on hospital and physician services remained virtually flat because a portion of these expenditures became part of the payments to managed care organizations.

Staff from the Department of Health Care Policy and Financing, which manages most of the state's Medicaid program, estimate that the program's departmental expenditures will be $2.5 billion in state and federal funds in SFY 2002 and that the program will grow 9 to 10 percent a year over the next several years, with growth coming as a result of increasing numbers of Medicaid eligibles, particularly noncitizens and children, and service expenditure growth. This relatively rapid growth could "crowd out" other programs because of the constitutional limit on public expenditure growth from one year to the next. Over time, with the aging of the population and the slowing economy, the state will face tough choices regarding Medicaid.

Medicaid cost containment efforts for SFY 2002 affect providers and beneficiaries. In addition to changes to the pharmaceutical budget, hospitals no longer receive facility fee payments when physicians deliver outpatient services in hospitals.[11] (Hospital inpatient and outpatient services usually result in two payments: one for the physician and one for the facility.) The state's reevaluation of the eligibility of disabled Medicaid beneficiaries is expected to reduce their number by several hundred and thus generate cost reductions; the state has also implemented changes to Medicaid's estate recovery program.

Despite these efforts, the state increased payments to certain providers. Nursing homes, alternative care facilities, home care agencies, and federally qualified health centers received rate increases. The method of determining nursing facility reimbursement rates

are in statute, and the formula typically generates an increase in rates of 3 to 5 percent a year. Home care agency and alternative care facility (e.g., assisted living facilities) rate increases were designed, in large part, to help providers recruit workers through higher wages.

Health Insurance Coverage for Children

Other than Medicaid, Colorado has one major public health insurance program for low-income children—Colorado Child Health Plan Plus (CHP+). This program was created using funds from the federal-state Children's Health Insurance Program (SCHIP), which entitles states to grants to help create and expand insurance programs for low-income children through age 18. The federal match rate for Colorado is 65 percent and is limited to $46.9 million a year.[12] The state anticipates that 40,688 children will participate in SCHIP in SFY 2002, up from 16,000 in SFY 1999.[13] Total expenditures in SFY 2002 are projected to be $47.1 million.

The predecessor to Colorado's SCHIP program was the state-sponsored Colorado Child Health Plan, which provided primarily outpatient services to low-income children in rural areas of the state. In 1998, CHP+, which provides coverage to children through age 18 with family incomes up to 185 percent of the federal poverty level, replaced this program. Colorado's CHP+ program counts family income in determining whether children qualify for the program, but there are adjustments to income calculations to account for such things as child care and significant medical expenses so that some people with higher gross incomes can qualify. The CHP+ program originally included assets in its means-test but found this practice to be administratively complex and a barrier to enrollment and so eliminated the asset test.

As of June 2001, 32,588 of the estimated 70,000 potentially eligible children were enrolled in Colorado's CHP+ program.[14] Imposition of relatively high premiums (up to $360 annually) and the method by which they were collected were thought by state officials to be partially responsible for preventing Colorado from reaching enrollment goals. As of April 2000, about 4,800, or 37 percent, of the 13,000 families enrolled in CHP+ were behind in paying their premiums and faced disenrollment from the program.[15] These 4,800 families represented about half of those required to pay premiums. Opposition to these premiums peaked in the summer of 2000 and Governor Owens responded by declaring a premium holiday from September 2000 through December 2000. In 2001, premiums were replaced with a $25 annual premium for one child and $35 for two or more children in families with incomes above 150 percent of the federal poverty level.

Colorado has devoted significant effort to CHP+ outreach by providing Child Health Advocates, which conducts outreach, eligibility determination, and enrollment, with over $1 million to conduct school and community outreach programs. In addition, the state, in consultation with advocates, determined which community organizations were likely to be the most effective in enrolling children and began setting up Satellite Eligibility Determination (SED) sites throughout the state. The sites help families fill out and mail their applications. Community organizations also competed for separate funding to enroll children in CHP+ with about $250,000 in mini-grants available in 2000 and $350,000 in 2001.

Some coordination issues have arisen between CHP+ and Medicaid. For example, some application forms have gotten lost or take weeks to be processed; the state's response was to fund three full-time equivalent employees at Child Health Advocates, which receives half of the CHP+ application forms, to screen for Medicaid eligibility. In addition, the Colorado state auditor reported that Medicaid does not provide families denied Medicaid coverage with information about CHP+.[16]

Benefits for children enrolled in CHP+ are comparable to the basic benefit level mandated by the state in the small group insurance market and are very similar to the state employees' benefit package, but they are not as comprehensive as Medicaid benefits. The CHP+ plan covers visits to doctors and clinics for preventive, acute and specialty care,

TABLE 3. Medicaid Enrollment and Expenditures in Colorado, 1998

	Colorado, 1998			Average Annual Growth (%), 1995–1998					
				Total Annual Expenditures		Avg. Monthly Enrollment		Expenditures per Enrollee	
	Total Annual Expenditures (in millions)	Avg. Monthly Enrollment (in thousands)	Avg. Annual Expenditures per Enrollee	Colorado	United States	Colorado	United States	Colorado	United States
Total Expenditures	**$1,655**	**–**	**–**	**7.7**	**3.9**	**-**	**-**	**-**	**-**
Medical Services									
By Eligible Group	**$1,451**	**253**	**$5,731**	**7.4**	**5.1**	**–2.5**	**–1.0**	**10.2**	**6.1**
Elderly	$451	36	$12,558	8.2	4.3	2.2	0.1	5.9	4.2
Blind and disabled	$613	57	$10,745	8.9	8.5	2.9	3.6	5.8	4.7
Adults	**$140**	**38**	$3,649	–6.0	–1.4	–13.3	–4.4	8.4	3.1
Cash assistance	$47	15	$3,136	–16.5	–10.4	–24.0	–14.9	9.9	5.3
Other enrollees	$93	23	$3,978	1.9	7.8	–1.8	9.3	3.8	–1.4
Children	**$247**	**122**	$2,028	13.0	2.7	–1.7	–1.5	14.9	4.3
Cash assistance	$53	36	$1,467	–13.0	–8.8	–21.3	–12.2	10.5	3.9
Other enrollees	$194	86	$2,265	28.9	12.4	16.5	9.8	10.6	2.4
By Type of Service	**$1,451**	**–**	**–**	**7.4**	**5.1**	**–**	**–**	**–**	**–**
Acute care	$814	–	–	6.2	4.0		–	–	–
Long-term care	$637	–	–	9.1	6.5	–	–	–	–
						–			
DSH	**$139**	**–**	**–**	**9.6**	**–7.3**	**–**	**–**	**–**	**–**
Administration	**$65**	**–**	**–**	**9.7**	**8.5**	**–**	**–**	**–**	**–**

Source: Urban Institute estimates based on data from HCFA-2082 and HCFA-64 reports.

Note: Does not include the U.S. Territories. Enrollment data shown are estimates of the average number of people enrolled in Medicaid in any month during the fiscal year. Expenditures per enrollee shown reflect total annual expenditures on medical services for each group, divided by the average monthly enrollment within that group. "Cash assistance" refers to enrollees who receive AFDC/TANF or SSI, or who are eligible under Section 1931 provisions. "Other enrollees" include the medically needy, poverty-related expansion groups, and people eligible under Medicaid Section 1115 waivers. "Acute care" services include inpatient, physician, lab, X-ray, outpatient, clinic, prescription drugs, EPSDT, family planning, dental, vision, other practitioners' care, payments to managed care organizations (MCOs), and payments to Medicare."Long-term care" services include nursing facilities, intermediate care facilities for the mentally retarded, inpatient mental health services, home health services, and personal care support services. "DSH" stands for disproportionate share hospital payments.

Note: Figures may not add to totals due to rounding.

inpatient and outpatient hospital services, emergency care, prescription drugs, glasses and hearing aids, and behavioral and mental health care, family planning, prenatal care, and outpatient substance abuse treatment.[17] The CHP+ program will add dental benefits in SFY 2002.

Where available, enrollees in CHP+ receive their health services from managed care plans. However, in rural areas of the state, managed care is less pervasive because of provider supply issues. While only 37 of Colorado's 63 counties have contracts with participating managed care plans, state officials estimate that 85 percent of CHP+ enrollees reside in these 37 counties, which are located in along the eastern edge of the Rocky Mountains and include the Denver metropolitan area. In the remaining counties, CHP+ enrollees obtain their care from a network of more than 1,000 primary care physicians who receive capitated payments and specialists who receive fee-for-service payments.

If CHP+ plans discover that any of their enrolled children have special needs, the children are referred to the state's Title V programs, which can provide case management and supportive services to supplement the services available from the managed care plans. Colorado also has a Robert Wood Johnson grant entitled "Children's Comprehensive Care Project," which examines the kinds of systems that are needed for children with special needs such as asthma and attention deficit disorder; three of the largest HMOs in CHP+ are participating. Pilot test results will be incorporated into future contracts governing participating plans.

The state pays the same capitation rates to all CHP+ managed care plans. The rates are age and income adjusted using nine rate cells. CHP+ and Medicaid capitation rates are different; however, state officials and plan representatives were reluctant to characterize one as higher or lower than the other because of the different benefit packages involved.

Administrative expenses had consumed a very high portion of the CHP+ program's expenditures—estimated to be 27 percent of total program costs in fiscal year 2000,[18] which exceeded the federal limit of 10 percent. Part of the high administrative costs were due to initial implementation costs and disagreements over accounting practices with the Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration). In 2001, state officials say that administrative costs represent less than 10 percent of expenditures in part due to the rapidly increasing enrollment rate.

Among the issues for future consideration are the type of mental health benefit CHP+ should offer and how best to enroll children whose parents are not used to dealing with public sector programs. Colorado has no plans to cover the parents of children in CHP+.

Acute Care Issues

Colorado's health care delivery system for Medicaid beneficiaries is dominated by managed care plans. And the state's safety net programs and providers are increasingly strained because of the high demand for services and the relatively low percentage of provider costs that some of the safety net programs cover. Controlling Medicaid prescription drug expenditure increases also presents a challenge to the state.

Medicaid Managed Care

Colorado was one of the first states to obtain a federal waiver to mandate that most Medicaid beneficiaries enroll in primary care physician (PCP) programs. In 1997, Colorado began requiring PCP enrollees, whose primary care physician belonged to a network of a Medicaid health maintenance organization (HMO), to enroll in that HMO or select another HMO. Other Medicaid beneficiaries, including those who are disabled, have a choice between primary care case management and entering an HMO. In SFY 2002, the state anticipates that 136,334 beneficiaries will receive care through five HMOs and 54,724 through the PCP program.[19]

The Medicaid program pays participating HMOs risk-adjusted capitated rates that are required by law to be limited to 95 percent of estimated fee-for-service costs. Payments

vary by diagnostic category and are adjusted for case mix, age, sex, disability status, and receipt of welfare.

Colorado has a contentious history with HMOs regarding the fairness and timeliness of state payments. In May 2000, a judge awarded Rocky Mountain HMO $18 million in back payments, and the state and the HMO agreed to have independent actuaries analyze the way the state sets its rates.[20] Likewise, the Kaiser Foundation Health Plan of Colorado filed suit in late 2000 to recover years of back payments that the DHCPF allegedly withheld.[21] State officials concede that they have had "some ugly battles" over HMO rates. These battles have delayed plans the state had to begin a competitive bidding process for Medicaid managed care plans.

An independent state audit of Medicaid payments to managed care plans in 2001 indicates that these payments, when adjusted, are about 98 percent of comparable fee-for-service costs.[22] The legislature's Joint Budget Committee requested the audit because DHCPF's original figures indicated that, between SFY 1998 and SFY 2000, Medicaid managed care plan per member per month rates increased 14 to 16 percent a year while fee-for-service costs increased about 4 percent from SFY 1995 through SFY 1999. After correcting a methodological error, the DHCPF showed that fee-for-service costs actually increased about 12 percent annually from SFY 1997 through SFY 1999.

Despite disputes over rates, Medicaid beneficiary surveys indicate reasonable levels of satisfaction with managed care plans and the primary care physician program. In 1998, the Department of Health Care Policy and Financing sponsored surveys of adults with and without disabilities in seven counties.[23] Sixty-three percent of adults with disabilities were satisfied with their HMOs, which was roughly the same percentage as adults without disabilities. Both groups were more satisfied with the PCP program than the HMOs, with the disabled group being the most satisfied with its PCPs at 79 percent. A 2000 survey found that adult Medicaid beneficiaries generally rated their health plans an 8 on a 10-point scale.[24] Although 80 percent of adults said they could get care quickly, about 40 percent said that getting customer service from their health plans was problematic. The results of the 2000 survey targeted to the experiences of children showed similar results.

Colorado contracted with First Peer Review of Colorado to study physician adherence to the Medicaid Primary Care Physician Program requirements, such as 24-hour telephone coverage.[25] The study found that 88 percent of physician practices with 25 or more Medicaid beneficiaries provided access to services that met the requirements. The study also sampled 244 client medical records and found that 99 percent of physician practices substantially complied with requirements concerning management of chronic illnesses, but results for some of the indicators, such as those related to documentation in medical records, were uneven.

Most observers said that the state's shift to Medicaid managed care generally has been successful. The state cited improved access to care for enrollees in managed care plans and enrollee satisfaction rates comparable to those of beneficiaries in the PCP program. And the hospitals report that HMOs are paying them at Medicaid rates but utilization has gone down.

Indigent Care Programs and Safety Net Providers

Colorado funds indigent care through several major programs:

- Medicaid Disproportionate Share Payments to Hospitals (DSH) program, which amounted to $174.9 million, including $87.4 million in federal funds in SFY 2001.[26]
- Denver Indigent Care and University Hospital Major Teaching Hospitals programs, which received $42.3 million in SFY 2001, including about $21 million in federal funds.
- Outstate Medically Indigent Care, which totaled $16.3 million in SFY 2001, including $6.5 million in federal funds.
- Two grant programs—Comprehensive Primary and Preventive Grants and Essential Community Provider Grants—which totaled $4.8 million in SFY 2001.

The first three programs obtain their federal funds using the Medicaid DSH strategy under which states make lump sum Medicaid payments to providers, obtain federal matching payments, and finance the state share with intergovernmental fund transfers. Because the payments are not based on actual services rendered, either the state or provider can earn large net increases in federal funding, which they can use to provide health care to indigent persons. The state does not yet use a similar provision—the Medicaid upper payment limit strategy—to obtain indigent care funds but plans to do so in the future.

Colorado's indigent care programs (Denver Indigent Care and University Hospital Major Teaching Hospitals programs and Outstate Medically Indigent Care) are designed to pay hospitals, physicians, and laboratories for the partial cost of treating people without health insurance. The programs are open to persons with incomes and assets (financial assets must be spent down) at or below 185 percent of the federal poverty level and who are not eligible for Medicaid. Those with incomes and assets at or below 40 percent of the federal poverty level have copayments limited to $120 a year; all others have limits set at 10 percent of family income.[27]

The indigent care programs served 150,000 people in SFY 1999, 16.5 percent of whom were children age 18 and under.[28] Providers must prioritize those to whom they deliver services; those with emergency needs should get served first, second are those with serious medical conditions, third are those needing any other medical care. Ninety-eight percent of services delivered were categorized as outpatient care in SFY 1999.[29]

The two largest providers of indigent care program services were Denver Health and Hospitals and clinics outside of the Denver metropolitan area. To participate, the programs' providers must be licensed as a hospital or clinic, provide a minimum of 3 percent charity care, and have at least one on-site physician to provide nonemergency obstetric care.

Under the indigent care programs, inpatient hospital admissions declined from 15,200 in SFY 1997 to 12,676 in SFY 1999.[30] There were 519,561 outpatient visits in SFY 1999, down from 593,107 visits in SFY 1997. Reportedly, fewer individuals qualified for the indigent care programs because their wages increased due to the strong economy of the late 1990s. However, state officials raised concerns about people in rural areas having sufficient access to care and how the slowing economy could increase demand for indigent care in the state.

The largest safety net providers in Colorado are located in the Denver metropolitan area.[31] Denver Health Medical Center is the largest safety net hospital in the state and is linked with a system of 10 clinics. This system along with other safety net providers is part of Colorado Access, a managed care plan that covers about 60 percent of enrollees in the Medicaid capitated managed care market. Other important safety net hospitals in the Denver metropolitan area are University Hospital and Children's Hospital.

In 2001, the University of Colorado Hospital announced that it would have to curtail its provision of charity care due to growing demand for services and increasing health care costs. The hospital asserted that the funding it receives is insufficient to treat all of the uninsured, given rapidly rising technology costs, nursing shortages, and prescription drug costs. In 1999, University Hospital said that it suffered a $9.8 million loss after admitting too many uninsured patients, forcing administrators to follow state law that requires hospitals to give priority to the sickest patients.[32]

According to the Colorado Health and Hospital Association (CHHA), some of the Medicaid cost containment efforts in SFY 2002 are going to adversely affect safety net hospitals. The DHCPF did not grant an inflation increase to hospitals and eliminated the facility component of hospital outpatient clinic services. The latter provision hit three hospitals hardest—University, Children's, and Denver Health. Twenty-five other hospitals will be affected to a lesser degree. According to CHHA, hospitals will have to determine whether they can keep their clinics open to Medicaid patients.

Due to the economic situation of certain safety net hospitals, some state officials and providers raised concerns about access to tertiary care for the uninsured and access to all care in rural areas. The Colorado Coalition on Access for the Medically Underserved and Colorado Community Health Network have helped address tertiary care access by developing a specialty referral network where physician specialists will waive their fees for people with few resources. They are also working with local hospitals to get them to donate their services to the uninsured. The specialty network will take referrals from the Colorado Community Health Network. Although the community health centers provide primary care, they do not have the resources to support tertiary care. University Hospital used to be the source of tertiary care for people outside of the Denver metropolitan area, but the hospital is increasingly saying that it cannot treat certain people without insurance because of financial losses.

A new source of private funds for health care resulted from the conversion of Blue Cross/Blue Shield in 1999 to for-profit status as a result of purchase by Anthem Health Care Inc. To receive state permission to do so, Anthem had to prove that the change would benefit Colorado residents and had to agree to continue to offer the former Blue Cross/Blue Shield products and individual and group insurance policies at their current rates. The conversion resulted in the creation of "Caring for Colorado," a $155 million health care foundation that began awarding grants in the summer of 2001.[33]

Prescription Drug Coverage

Medicaid prescription drug costs grew 30 percent from SFY 1997 to SFY 2000.[34] In reaction to these expenditure increases, the state in SFY 2002 reduced pharmacist dispensing fees and reimbursement for ingredient costs and increased beneficiary copayments. State officials believe that controlling these cost increases will be a particular problem in the future because the state believes it has few tools to reduce manufacturer prices. Colorado has no plans to provide prescription drug coverage to Medicare beneficiaries through a state-funded pharmaceutical assistance program because the governor, among others, believes that this should be the responsibility of the federal government.

Issues in Long-Term Care for Older People and Younger Persons with Disabilities

Colorado's public programs for people with disabilities vary by type of disability. The state uses a single-point-of-entry system to manage home and community services and nursing home care for older persons and younger persons with physical disabilities. Services for older persons are dominated by nursing home care, where quality issues have arisen. Those persons with mental health conditions or developmental disabilities primarily receive services in the home and community. Managed care dominates delivery of mental health care to Medicaid beneficiaries, and the state relies on community-centered boards to manage home and community services for persons with developmental disabilities. Although the labor shortage among entry-level long-term care workers was of concern, it appeared to be particularly problematic among home and community service providers. The need to respond to the Supreme Court's *Olmstead* decision, which creates a limited right to home and community services for people with disabilities under certain circumstances, was considered a future challenge primarily for the mental health care system.

Background on Providers of Services

The number of nursing home residents in Colorado ranged between 15,000 and 16,000 between 1992 and 1998.[35] About 61 percent of these residents depended upon Medicaid to finance their care in 1998, a little less than the national average. Eight percent of residents received their funding from Medicare and 30 percent paid privately or had other sources of funding.[36] In 1998, Colorado had 51.5 nursing home beds per 1,000 persons age 65 and

over, close to the national average of 52.5.[37] The nursing home occupancy rate dropped from 88 percent in 1996 to 83 percent in 1998.[38]

Group residential settings have been increasing rapidly so that by 1998, there were 27.1 beds per 1,000 persons age 65 and over, compared to the national average of 25.5 in 1998. Until 1998, Colorado had a moratorium on certification of additional Medicaid nursing home beds but no certificate of need or moratoria on other long-term care providers.

While the number of nursing home beds has grown slowly over time, the number of intermediate care facilities for the mentally retarded (ICF/MR) beds has been decreasing rapidly so that in 1998, the state had .05 beds per 1,000 Coloradans, much lower than the national average of .47. Adult day care and home health agencies are not licensed in Colorado but the state does certify the agencies. There were 163 certified home health agencies in 1998, a decline of approximately 40 from the previous year.[39] Certified hospice agencies grew from 29 in 1997 to 40 in 1998.

Services for Older Persons and Younger Adults with Physical Disabilities

Colorado has one of the more innovative home and community services systems for older persons and younger adults with physical disabilities because it uses a single-point-of-entry system to determine whether Medicaid beneficiaries should receive home and community services or nursing home care. The state has a large waiver serving the aged, blind, and disabled, which provides home and community services to about 13,000 Medicaid beneficiaries at a cost of $64.2 million in SFY 2000.[40] About 6,600 beneficiaries received the state's mandatory home health services at a cost of $66.9 million in the same year. The state also has a Home Care Allowance program that uses state funds to make cash payments to people with disabilities. In 1998 the state extended nursing home spousal impoverishment protections to persons receiving home and community services.[41]

A 2001 report from the state auditor raised concerns about the state's effectiveness in containing the costs of Medicaid home and community services for the aged, blind, and disabled, and assuring the quality of those services.[42] Regarding cost containment, the audit found some recipients of home and community waiver services were not functionally eligible for them and recommended that the state examine its eligibility determination processes. Regarding quality, the report showed (1) inconsistent citation of deficiencies and documentation of provider survey results, (2) inadequate complaint investigations, and (3) lack of intermediate sanctions for providers with serious deficiencies. Now the state's only recourse is to terminate the provider's Medicaid contract. State officials generally agreed with the audit's findings.

In terms of future challenges, state officials point to the need to address the labor shortage in home and community settings and resulting challenges to quality assurance. For example, the shortage could lead to missed visits that could complicate medication management for older Medicaid beneficiaries living at home.

Nursing Home Care

Most older Medicaid beneficiaries receive their long-term care services in Colorado's nursing homes, which have faced a series of quality assurance challenges. Data from a recent report show that the average number of deficiencies for a Colorado nursing home was 2.2 in 1998, compared to 11.7 in 1992.[43] The percentage of nursing homes with no deficiencies rose from 2.1 percent in 1992 to 34.9 percent in 1998. These data do not indicate whether quality improved in nursing homes or surveyors were less stringent in their quality assurance activities. However, in 2000, the state auditor reported that surveyors sometimes overlooked quality problems with medical treatment, pain management, and infection control.[44] The auditor also showed that complaint investigations were delayed and reporting requirements were not followed. The auditor found no evidence that Colorado's Quality Care Incentive Payment program, which is supposed to provide financial rewards to facilities that deliver good quality care, improved quality because measures of quality were insufficient. In addition, the criteria for receipt of payments were considered to be

too lenient, with 99 percent of all facilities submitting documentation receiving the payments in SFY 1999.

The governor responded to these findings by allocating funding to the Department of Public Health and Environment in the SFY 2000 budget to hire 11 new staff members devoted to improving nursing home inspections.[45] Legislation enacted in 2001 requires this department to implement a consumer satisfaction survey for nursing home residents and to respond within five working days to complaints about nursing home quality.

Elimination in 1997 of the federal Boren amendment, which required that Medicaid pay providers reasonable and adequate rates "to meet the costs which must be incurred by efficiently and economically operated facilities," has allowed the state to pursue a number of provider rate changes. The state capped certain cost centers for nursing homes and decreased annual cost increases from 9 to 10 percent a year to 3 to 4 percent a year. Further changes are in store for nursing home rates because a 2000 law requires establishment of a case-mix adjusted reimbursement system for nursing facilities participating in Medicaid.[46]

Programs for People with Mental Health Conditions

According to state officials, in SFY 2000 Colorado's community mental health system served about 80,000 people (40,000 on Medicaid and 40,000 others) with $176 million in state and federal funds. Medicaid beneficiaries who need mental health care receive services through a managed care system, while non-Medicaid clients receive services through community mental health centers directly.

In 1995, Colorado implemented the Medicaid Mental Health Capitation and Managed Care Program on a pilot basis and expanded the program statewide in 1998.[47] The program gives eight local Mental Health Assessment and Services Agencies (MHASAs) responsibility for providing or arranging for any necessary mental health services that are appropriate for the Medicaid beneficiaries in their catchment areas. MHASAs receive monthly capitated payment rates that are based on historical costs of Medicaid mental health services; the rates are adjusted by eligibility category, geographic area, and cost of living.[48] Any prescription drugs the participant needs are billed either directly to Medicaid on a fee-for-service basis or to the beneficiary's managed care plan.[49] In SFY 2002, the state began devoting 2 percent of its budget for Medicaid mental health services to provide financial incentives for MHASAs to improve their performance, which will be measured through such indicators as consumer and family satisfaction rates and percentage of Medicaid beneficiaries served.

A 1998 state auditor's report had three findings related to capitation of Medicaid mental health services. First, the report showed that capitated payment rates varied among the MHASAs by eligibility category and within categories.[50] For example, payments for the Supplemental Security Income disabled group varied considerably among the local agencies. In response to this finding, the Department of Human Services is examining ways to even out rates among the eight MHASAs. Second, the auditor's data indicate that costs per beneficiary rose more quickly after implementation of the capitation pilot than before its implementation, but state officials disagree with this contention. Third, the report found that the number of Medicaid beneficiaries using mental health services leveled off after the introduction of managed care and some beneficiaries reported that they were refused services.[51] On the other hand, two reports assert that the managed care pilot program resulted in a number of improvements, including expanding services to a higher percentage of Medicaid beneficiaries, reducing waiting lists, improving coordination of services, and producing cost savings for the state.[52] State officials believe that the overall effects of Medicaid managed mental health care have been positive.

Medicaid beneficiaries have relatively better funding of their mental health services than other users of community mental health centers. According to state officials, 40,000 Medicaid beneficiaries with any type of need for mental health care received $135 million in state and federally funded services while 40,000 non-Medicaid users received $41 million in state and federally funded services in SFY 2000.

Colorado's non-Medicaid mental health programs are not capitated and the Department of Human Services has separate contracts with community mental health centers for these clients. The centers must screen everyone who contacts them and provide emergency services and hospitalization if necessary. According to state officials, the centers generally have long waiting lists because resources are insufficient to serve everyone in need. For example, non-Medicaid applicants needing services can wait as long as six to nine months for services. Community centers also receive local funds to help serve non-Medicaid clients.

The mental health system's future challenges include complying with the U.S. Supreme Court's *Olmstead* decision, treating people with mental illness in prison, and measuring unmet need for services. In response to problems the state has had serving youths in correction facilities, recent legislation requires screening of everyone in the prison system to determine the need for mental health services in this setting. Finally, the department has an analysis under way to estimate how many people with mental illness the state is currently serving and how many receive service privately, and, using national estimates, to project the number who are not served.

Programs Serving Persons with Developmental Disabilities

In SFY 2001, Colorado's Developmental Disabilities Services served about 9,000 people with a budget of $280 million through contracts with 20 community-centered boards to provide services to persons with developmental disabilities.[53] The major categories of services available in the community are case management, early intervention services for infants and toddlers, family support services, supported living services, and comprehensive services, which include residential and day services. The community-centered boards provide services to at least 6,551 adults and 2,519 children and their families at a cost of $221 million in SFY 2000; 3,130 of the adults lived in "out-of-home" residential settings. In SFY 1999, 458 people lived in the Department of Human Services' three regional centers.[54]

In the late 1990s, Colorado began a new "systems change" effort. One of the changes involved reforming the payment mechanism for the community-centered boards; beginning in July 1999 boards began receiving a pool of money for individuals served in the supported living services program, which is used for an individually tailored set of services for each client. The community-centered boards receive capitated payments of $13,000, with service plans ranging in cost from $1 to $35,000 a year. Boards are responsible for negotiating rates with providers.

The Office of the State Auditor examined services and costs for 39 people in regional centers and 21 in community residential settings and found no "relationship between service levels, costs, and…amount of funds required to serve people appropriately."[55] The auditor also found an inconsistent assessment process across the state and no established criteria for entering a center or living in the community. People with developmental disabilities can remain on waiting lists for community Medicaid waiver services for several years. In addition, community staff providing direct care have no minimum training requirements and may lack the skills necessary to serve people with developmental disabilities.

Another issue the auditor's review raised was that of safety.[56] The Department of Human Services does not identify and track beneficiaries who pose risks to others. And, in 3 of the 11 settings the auditor's staff visited, residents with a history of aberrant behavior were allowed easy access to children and other vulnerable groups.

State officials report that community program homes are facing challenges around labor and training costs, resulting in the state-operated regional centers having better paid and trained staff than the smaller group homes. In response to the labor shortage, the state has given the system an additional $16.2 million in SFY 2001, which includes a 5.3 percent increase in payments to community boards plus a 2.5 percent cost of living adjustment. Most of the funding will be used for the rate increases, but other uses of the funding include providing more people with the opportunity to receive comprehensive services,

transitioning children out of foster care when they become adults, providing services in emergency situations such as when an older caregiver dies, and removing 30 people from the 1,200-person waiting list in the state.

The future challenges facing the department are the quality of the labor force and the need to reduce the waiting list for services. The future may hold more local variation as the community-centered boards adjust to their new flexibility. The Department of Human Services is also working to develop a tool that would categorize people by their level of need to help in payment and service plan decisions.

Other Issues

The private market for health insurance has been one of the more contentious issues since reforms were passed in the mid- and late 1990s, with insurers wanting to weaken consumer protections because of the financial challenges they face. The provider market has also experienced some turbulence among physician groups, while the hospital market has remained relatively stable.

Insurance Market Reforms and Market Developments

In 1994, Colorado established a number of reforms designed to increase the access of individuals and small employers to private health insurance. Colorado's reforms included rate restrictions, guaranteed renewability and portability of policies, community rating, and limitations on preexisting condition clauses.[57] In 1997, the state enacted legislation that brought its individual and group markets into compliance with new federal standards required by the Health Insurance Portability and Accountability Act.

In 1998, an evaluation of Colorado's small group health insurance laws found that they did not cause major insurance market disruptions; the market remained highly competitive in price, product diversity, and number of carriers.[58] The law was effectively administered, enrollment in plans held steady or increased, and standardized benefit plans sold well. Some insurers had left the market and competition among insurers was thinning out in rural areas.

However, Colorado's reform law remains highly controversial, especially the move to modified community rating, and insurers view Colorado as a state with a difficult regulatory environment.[59]

Compliance with small group reform provisions was a contentious issue throughout 1998. The insurance commissioner issued several fines against prominent insurers for violating various rules, including the 1997 small-group laws, discovered during market conduct examinations.[60]

The state made minor modifications to rules governing its small group market in 2000 and 2001, in response to insurers' attempts to change the state's modified community rating in which rates can be adjusted for plan design, age of employees, family composition, and geographic area but not for health status. Rule changes included restrictions on open enrollment periods among other measures.

The state has a high-risk pool—Cover Colorado—that served 1,389 people as of April 2000.[61] The program is designed for people who are unable to obtain coverage through the individual market or whose premiums are unaffordable. Cover Colorado limits premiums to 150 percent of the rate for a standard benefit package and, according to state staff, premiums remain at about 120 percent of this rate. A new assessment on insurers will fund Cover Colorado.

The legislature established an independent review process for denial of claims in 1999.[62] Colorado's law allows individuals with health insurance coverage to request independent, external reviews within 60 days of receiving denials of medical treatments or services. Colorado requires a two-tier internal review of claims of any amount denied due to a finding that the service is not medically necessary or to the experimental nature of procedures. The law sets time limits on internal reviews, which differ according to the type of claim, and an expedited review process is available. After the internal reviews are exhaust-

ed, enrollees are informed about their rights to an external review. The state assigns cases to a rotating list of eight external reviewers. The plan must send all records to the reviewer and has to pay the reviewers' costs, which range from $500 to $1,000. According to state staff, between June 2000, when the independent external claims review process began, and December 2000, 22 cases underwent review and 11 were decided in favor of the consumer and 11 for the plans. Since then the number of cases has grown, with 50 cases under review between January and April of 2001.

Provider Market Developments

With the exception of physicians, the provider market has remained relatively stable in Colorado over the last several years, but poor distribution of resources remains a challenge for the state. In the late 1990s, two large physician groups formed to compete for managed health care contracts. The first group, which encompassed eight large medical groups representing 1,600 physicians (nearly one in five physicians), formed an alliance called Millenial. Hoping to gain more control over medical decisions, Millenial negotiated a contract with PacifiCare, the state's second-largest insurer, under which Millenial assumed financial risk for delivery of health care services to enrollees. According to state staff, Millenial disbanded because of financial problems associated with the group's inadequate experience with handling financial risk. The second group was a partnership representing 1,400 physicians, with a goal of negotiating contracts with managed care plans that agree to eliminate the gatekeeper model and financial arrangements that give physicians incentives to withhold care.

Managed care plans have largely curtailed the practice of contracting with physician organizations to take on risk for health expenses beyond the scope of their practices. These risk contracts are no longer common because managed care plans have had to pay medical bills that the physician organizations were not able to pay. Colorado still has two large independent practice associations that negotiate with managed care plans, mostly over physician payment rates. However, some physicians do not join these associations because of complaints about late payments.

According to the state hospital association, hospital occupancy rates are strong, as is volume. In the Denver metropolitan area, periodically there is insufficient capacity in intensive care units and hospital emergency rooms. Emergency room admissions are up 25 percent in the last five years and 17 percent in the last two years. Emergency rooms are one of the primary sources of care for the uninsured, who have no other source of care.

State officials and consumer representatives indicate that there is a maldistribution of health care resources, with residents of urban areas having greater access to services than residents in rural areas. In addition, a shortage of nurses is affecting capacity to deliver services.

Conclusion

Colorado has had a relatively stable but increasingly strained health care system for people with low incomes. Medicaid, one of the cornerstones of this system, has not expanded markedly in terms of eligibility standards, although spending on and enrollment in Medicaid has grown since the late 1990s. However, the state has implemented a new State Children's Health Insurance Program that is modeled after private sector health plans in its benefit structure and reliance on managed care plans. Although the state's population with low incomes has a relatively high rate of private health insurance coverage, this coverage may erode as the economy deteriorates.

Further expansions of public sector health care programs do not appear likely because the governor supports private sector expansions and the state has constitutional limits on revenues and public expenditures. However, advocacy groups have banded together to promote coverage of the uninsured and do not plan to back off of their commitment to advocate for this population. In fact, some groups have contemplated trying to eliminate the constitutional limit on spending.

The constitutional limit on spending places considerable pressure on Medicaid to control its cost growth. To do so, Medicaid relies heavily on managed care for programs serving children and younger adults with and without disabilities. There were relatively large increases in spending on managed care plans between SFY 1998 and SFY 2000; these increases may not be sustainable over time. The state has implemented Medicaid managed care programs to improve service delivery, which by some measures they have.

The issues facing the state's publicly funded programs for persons with disabilities vary by population. Quality assurance has been problematic for home and community services as well as nursing homes. Recruiting qualified workers to serve those with developmental disabilities is among the key issues for that population. Programs for people with mental health conditions are facing pressures due to the Supreme Court's *Olmstead* decision.

One of the more controversial aspects of the state's health care system is Colorado's modified community rating for small group health insurance plans. Certain insurers have repeatedly tried to eliminate community rating, claiming that this increases their expenses and makes it difficult for them to remain in the small group market. To date, the community rating system remains in place but there will certainly be future attempts to modify it.

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k. In 1996, the threshold represents the state Medicaid threshold for poverty-related eligibility or AFDC-related eligibility. Higher thresholds for separate state-financed programs (such as in New York) are not represented here.

l. The figure for 1998 represents the higher of the state threshold for Medicaid eligibility, or the state threshold for Medicaid expansions or stand-alone programs enacted under the SCHIP legislation.

m. The figure for 2000 represents the higher of Medicaid or SCHIP eligibility. In 2000, all states covered at least some children through SCHIP; certain groups in some states are only eligible through Medicaid.

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