Health Policy for Low-Income People in Colorado

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This report is part of The Urban Institute’s *Assessing the New Federalism* project, a multi-year effort to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director and Anna Kondratas is deputy director. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, Inc., the project studies child and family well-being.

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About the Series

Assessing the New Federalism is a multi-year Urban Institute project designed to analyze the devolution of responsibility from the federal government to the states for health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments. In collaboration with Child Trends, Inc., the project studies changes in family well-being. The project aims to provide timely nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia, available at the Urban Institute’s Web site. This paper is one in a series of reports on the case studies conducted in the 13 states, home to half of the nation’s population. The 13 states are Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin. Two case studies were conducted in each state, one focusing on income support and social services, including employment and training programs, and the other on health programs. These 26 reports describe the policies and programs in place in the base year of this project, 1996. A second set of case studies to be prepared in 1998 or 1999 will describe how states reshape programs and policies in response to increased freedom to design social welfare and health programs to fit the needs of their low-income populations.

The income support and social services studies look at three broad areas. Basic income support for low-income families, which includes cash and near-cash programs such as Aid to Families with Dependent Children and Food Stamps, is one. The second area includes programs designed to lessen the
dependence of families on government-funded income support, such as education and training programs, child care, and child support enforcement. Finally, the reports describe what might be called the last-resort safety net, which includes child welfare, homeless programs, and other emergency services.

The health reports describe the entire context of health care provision for the low-income population. They cover Medicaid and similar programs, state policies regarding insurance, and the role of public hospitals and public health programs.

In a study of the effects of shifting responsibilities from the federal to state governments, one must start with an understanding of where states stand. States have made highly varied decisions about how to structure their programs. In addition, each state is working within its own context of private-sector choices and political attitudes toward the role of government. Future components of Assessing the New Federalism will include studies of the variation in policy choices made by different states.
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Colorado, in the spirit of its frontier heritage, places a premium on independence and self-determination. Public policymaking in the area of health care reflects the value the state attaches to local solutions for local problems and private-sector initiatives. Efforts to reduce the size of government and grant more authority to localities are under way, and it has been predicted that with additional federal leeway—for example, Medicaid block grants—the state would shift even more responsibility to local governments. Fiscal policies currently in force tightly constrain public revenues and expenditures, even as the state economy surges upward.

In further keeping with its desire for smaller government and independence from federal control, the state has resisted expanding entitlement programs. Consequently, Colorado’s Medicaid program is fairly lean, and at one point the legislature even voted to abolish it—an act that was subsequently vetoed by the governor. Modest expansions in health care coverage have come through Colorado’s own state-supported health programs, rather than through the federal entitlement of Medicaid. In the opinion of some observers, the state’s minimalist approach to financing health insurance for low-income people is sufficient, given the availability of public hospitals and, as a last resort, emergency rooms.

Health policy developments in Colorado in recent years have emerged from political consensus between conservative and liberal, as well as urban and rural, factions. Colorado is a very rural state geographically, with nearly half of its counties containing six or fewer persons per square mile; however, only about 15 percent of the state’s population lives in nonmetropolitan areas. Relative to the national average, Colorado’s population is young, fast-growing, and increasingly wealthy. Colorado is a fiscally conservative state,
although there are pockets of liberalism in some urban areas. The state’s conservative nature is evident in its budgetary policies. A citizen-initiated referendum passed in November 1992, referred to as TABOR (Taxpayers’ Bill of Rights), made an earlier 6 percent annual limit on state budget growth part of the state constitution. Any excess revenues in a given year must be refunded to the taxpayers of Colorado, which occurred for the first time in 1997. Because TABOR for the most part is a “zero-sum game,” Medicaid, with its high rate of growth in recent years, is viewed as a limit to flexibility in financing other state activities.

Medicaid receives considerable attention from the Colorado legislature, but largely with an eye to keeping the program from growing ever larger. In 1995, Medicaid accounted for 18.2 percent of state general fund expenditures, up from 10.4 percent in 1990. With a growth rate of 20.8 percent over that period, it was the fastest growing major public expenditure. The goal of the state seems to be to achieve savings in Medicaid and direct some of those dollars to health programs that avoid the eligibility and benefit requirements of Medicaid. Limiting program eligibility primarily to federally mandated categories is one strategy the state has adopted to achieve savings. The legislature’s main initiatives to expand Medicaid coverage, authorized in the 1997 session, are buy-in programs for former welfare and disabled Medicaid recipients who return to work, which will extend their Medicaid coverage indefinitely. The buy-in nature of the program is consistent with Colorado’s philosophy of making health care available without increasing government outlays.

Increasing the proportion of Medicaid recipients enrolled in managed care is another means Colorado has employed to reduce state expenditures. Colorado has been a forerunner in the area of Medicaid managed care. The state was one of the first to obtain a federal waiver to mandate that recipients enroll in a primary care case management (PCCM) program. A decade before that, in the mid-1970s, the first health maintenance organization (HMO) in the state to contract with Medicaid began to enroll beneficiaries voluntarily in a full-risk arrangement. Only recently, however, has the number of beneficiaries in HMOs increased substantially. HMO enrollment is proceeding rapidly under a state policy of moving PCCM enrollees into HMOs if their physician case manager belongs to the network of a Medicaid HMO. A relatively new Medicaid-only HMO, Denver-based Colorado Access, has benefited the most from this “rollover” policy and now counts as its membership more than half of the state’s Medicaid HMO enrollees. Legislation signed into law on June 3, 1997, builds on Colorado’s current efforts and establishes the goal of 75 percent enrollment of Medicaid clients in managed care by the year 2000. Currently, any HMO may participate in Medicaid if it meets the requirements of the contract, but by January 1999, the state plans to institute competitive bidding for contracts. Colorado Access, which is thriving financially, is concerned that competitive bidding could force it to reduce payments to safety net providers in its network, which in turn could adversely affect the providers’ ability to serve the uninsured.
Working outside the confines of Medicaid, the state has operated several smaller state-only health care programs, including the Colorado Indigent Care Program (CICP) and the Child Health Plan (CHP). CICP provides inpatient and outpatient coverage for uninsured residents of all ages with income and assets below 185 percent of the federal poverty level. The program is essentially a means to reimburse providers for a fraction (less than 30 percent) of the uncompensated care they provide. In fiscal year (FY) 1996 there were 133,772 unduplicated CICP users with 574,096 visits to hospitals and clinics. Funding for hospitals under CICP, which comes largely through the Medicaid disproportionate share hospital (DSH) program, equaled $34 million in 1996. Standard DSH payments to hospitals totaled $36 million in 1996–97. Denver Health Medical Center and University Hospital are major recipients of both programs, as is the state, which retained $150 million of the $361 million in federal matching funds generated through the DSH program between FY 1993-94 and FY 1996-97.

Prior to 1998, the CHP covered outpatient services for low-income children in rural areas under age 13 whose family income fell under 185 percent of the federal poverty level. Families paid an annual premium of $25 per child. Under the state’s recently passed House Bill 97-1304, the CHP is merged with CICP funding for children. Through capitated managed care plans, the new program offers inpatient and outpatient services for both rural and urban children up to age 18. One new source of program funds is a portion of the savings from expanding Medicaid managed care. In addition, the state has received federal approval for its plan under the new Title XXI (the State Children’s Health Insurance Program). With the flexibility to require cost-sharing that is not allowed under Medicaid, the CHP program and its predecessor permit Colorado to emphasize individual responsibility. Moreover, the state’s preference for private-sector solutions is evidenced in a related plan to use Title XXI funds to buy into employer-sponsored coverage for eligible children whose working parent has the option but cannot afford it.

The health care market in Colorado is undergoing rapid change. Informed estimates are that as much as 80 percent of the privately insured market in Colorado is enrolled in either HMOs or preferred provider organizations (PPOs). As elsewhere, this trend has put considerable pressure on providers, especially hospitals, to reduce prices and become more efficient. Mergers and joint ventures to reduce redundancies and to achieve economies of scale in purchasing, administration, and even patient care are commonly employed tools of efficiency that have been utilized in Colorado. Local hospitals that fear for their survival have merged with national hospital systems to take advantage of volume purchasing and reductions in administrative costs. Five major national hospital systems now own numerous hospitals in Colorado. And, since four of these systems have paired off to form joint ventures for their Colorado hospitals, there are really only three independent hospital systems in Colorado. Private insurance coverage is strong in the state, which helps to explain why the overall rate of uninsurance is low. An unusual number of small employers provide coverage to their workers, likely reflecting the good employment opportunities in these small firms and some of the small-group reforms enacted in Colorado to enhance the health insurance market.
Colorado has a relatively strong safety net of hospitals and clinics, supported in part by the CICP and DSH programs. The state’s public health system also meets some of the important health care needs of the uninsured, although increasingly the state is encouraging county health departments to shift their focus to core public health services, such as health promotion and infectious disease control. The Denver area boasts a particularly strong health care safety net, which is a dynamic component of the city’s highly competitive health care market. Throughout the 1990s, Denver has witnessed a consolidation of multiple hospitals into three large systems. Its large safety net providers, Denver Health and Hospital Authority (a publicly funded system that links a large hospital and 10 federally qualified health centers) and University Hospital, are independent but large and financially sound enough to be formidable competitors in the market, especially for Medicaid patients. Nevertheless, the safety net’s financial stability may be somewhat tenuous. The number of uninsured and underinsured persons in Colorado is apparently on the rise as a result of the increasing number of jobs that do not include health insurance benefits. In addition, more players are entering the Medicaid market through managed care contracts; the higher level of uncompensated care costs shouldered by safety net providers may render them comparatively less attractive to Medicaid-contracting HMOs.

As additional means to maximize state flexibility, Colorado has increasingly relied on Medicaid home and community-based care waivers and the state-funded Home Care Allowance program to deliver long-term care services. Nonetheless, institutional care, particularly nursing home care, still accounts for the majority of long-term care spending in Colorado, especially among the elderly population. The state has made greater strides in delivering Medicaid home and community-based care to persons with mental and developmental disabilities. In the area of mental health, growth in noninstitutional care alternatives has been stimulated by the Medicaid Mental Health Capitation pilot project, which is scheduled to be statewide in 1998. In the area of developmental disabilities, Medicaid waivers are the dominant vehicle for providing services. These waiver programs have generated controversy—and even lawsuits—as a result of lengthy waiting lists.

The chief challenge facing Colorado in the future will be how well the state can respond to an economic downturn. State programs, including Medicaid, offer only limited protections to Colorado’s citizens. The current low rates of uninsurance are due to a healthy economy and large numbers of small firms offering insurance to their employees. These factors could change suddenly, however. And the state’s system of support is not well equipped to expand to meet greater needs. The constitutionally required spending limits and the lean nature of the current Medicaid program mean that there is little room to stretch resources further. In addition, Colorado’s emphasis on moving its Medicaid recipients into managed care may place some strains on a relatively healthy system of safety net providers that currently serve the uninsured.
Sociodemographic Characteristics

With a population of 3.7 million, Colorado contains only 1.4 percent of the U.S. population. It ranks considerably below the national average in terms of percentage of persons ages 65 and over—8.5 percent versus 12.1 percent nationally in 1994–95. A larger share of the state’s population as compared with the national average is Hispanic, but African Americans are underrepresented in Colorado, making up only 2.9 percent of the total population. Like many of the mountain states, Colorado far exceeds the United States as a whole in population growth (13.7 percent versus 5.6 percent between 1990 and 1995). Although Colorado is a very rural state, with 31 of its 63 counties classified as “frontier,” only about 15 percent of the state’s population lives in nonmetropolitan areas. Its urban population is heavily concentrated on the “front range” of the state in a line that stretches north and south, encompassing areas north of Denver, and south through Colorado Springs and Pueblo (table 1).

Economic Status

Colorado’s economy has made a strong recovery from the period when the state’s oil industry collapsed in the late 1980s and early 1990s. During this time,
### Table 1  State Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Colorado</th>
<th>United States</th>
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<tr>
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<td>Population (1994–95)a (in thousands)</td>
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<td>Percent under 18 (1994–95)a</td>
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<td>26.8%</td>
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<td>11.8%</td>
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<tr>
<td>Percent Non-Hispanic Other (1994–95)a</td>
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<td>Percent Noncitizen Immigrant (1996) *</td>
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</tr>
<tr>
<td>Population Growth (1990–95)b</td>
<td>15.1%</td>
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<td>Unemployment Rate (1996)f</td>
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<td>12.4%</td>
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<td><strong>Health</strong></td>
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<td>Percent Uninsured—Nonelderly (1994–95)a</td>
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<td>15.5%</td>
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<td>5.9%</td>
<td>12.2%</td>
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<td>Percent Employer Sponsored—Nonelderly (1994–95)a</td>
<td>72.2%</td>
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<td>Smokers among Adult Population (1993)</td>
<td>23.8%</td>
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<td>Violent Crimes per 100,000 (1995)x</td>
<td>440.2</td>
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<td>AIDS Cases Reported per 100,000 (1995)x</td>
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<td>27.8</td>
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<td>Governor’s Affiliation (1996)p</td>
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<td>D</td>
</tr>
<tr>
<td>Party Control of Senate (Upper) (1996)p</td>
<td>15D-20R</td>
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</tbody>
</table>

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e. Personal contributions for social insurance are not included in personal income.


g. Employment rate is calculated using the civilian noninstitutional population 16 years of age and over.

h. CPS three-year average (March 1994–March 1996, where 1994 is the center year) edited using the Urban Institute’s TRIM2 microsimulation model.

i. “Other” includes persons covered under CHAMPUS, VA, Medicare, military health programs, and privately purchased coverage.


state government was affected as well. In fiscal year (FY) 1991-92 the state budget was cut by more than 2.5 percent. Colorado’s subsequent economic recovery is apparent from a number of indicators. In 1996, unemployment stood at just 4.2 percent, compared with a national average of 5.4 percent. The overall employment rate is also higher than the national average, reflecting both the low rate of unemployment and the relatively small proportion of older Coloradans. Per capita personal income has risen by nearly one-quarter since 1990, and because the population has been growing rapidly since the beginning of the decade, personal income growth is very high (41.3 percent from 1990 to 1995 compared with the national average of 27.7 percent), indicating a substantial economic base from which the state could potentially draw revenues. These statistics also translate into a lower overall poverty rate (9.3 percent in 1994) for Colorado compared with the United States as a whole, and a substantially lower rate of children in poverty (12.4 percent) (table 1). In fact, these rates are among the lowest in the country.

**Political and Budgetary Landscapes**

Colorado is a conservative state, with Republicans holding a commanding margin in both houses of the legislature. There is a split within the Republican party, however, between the socially conservative religious right and the fiscally conservative business community. The governor, Roy Romer, is a third-term Democrat who has been able to work with the legislature to avoid deadlock, particularly in the 1997 legislative session. The governor’s priorities have included a number of children’s initiatives that have been relatively well received by the legislature.

Colorado’s general approach to policymaking appears to be one of making incremental changes, a strategy that seems to have resulted in areas of compromise between the governor and the legislature. This balance may change substantially in the future because term limits in Colorado will have a major impact on the composition of the state legislature. In 1998, 28 of 100 legislators will be precluded from running for reelection, including all of the leadership and a majority of the members of the powerful Joint Budget Committee. Whether new legislators will be as interested in seeking consensus is unknown. The result of the coming gubernatorial election (Governor Romer cannot run again) may also affect consensus building and policymaking.

As in many states with a concentrated urban population and a large geographic area that has very low population density, Colorado’s political divisions often reflect urban-rural tensions. In addition, pockets of very conservative and very liberal citizens can be found throughout the state. For example, the Colorado Springs area has a very strong religious community that has pushed for conservative social legislation, and Boulder has a strong liberal community that has concerns about issues such as the environment and development.
Factors other than urban-rural and conservative-liberal splits are equally important in understanding the political environment in Colorado—namely, the strong fiscal constraints that the state has imposed on both its revenues and expenditures. In the late 1970s, a 7 percent spending limit was in force. A 6 percent limit was enacted in the 1980s. Building upon these restrictions are even more stringent limits passed in November 1992 as a citizen-initiated referendum. Variously referred to as TABOR (Taxpayers’ Bill of Rights), Amendment #1, or the Bruce Amendment (after its author), the referendum made the earlier 6 percent spending limit part of the state constitution.

With few exceptions, TABOR affects all public spending and requires that if revenues raised exceed the limit (as described below), the excess must be refunded to the citizens of Colorado. A refund was triggered for the first time in 1997. The state will return $139 million to taxpayers, largely as credits against 1997 taxes. Fiscal projections suggest similar situations will arise over the next five years.

TABOR limits (with only a few exemptions) the percentage increase in state public revenues and spending to either inflation plus the percentage change in state population in the prior calendar year or 6 percent, whichever is lower. In practice, the 6 percent limit has been the binding constraint. These restrictions effectively preclude the state coffers from benefiting from real per capita growth in state income without voter approval. For local districts, the maximum percentage increase in revenues and spending that is allowed is inflation in the prior year plus growth in property values.

TABOR expenditure limits can be exceeded only by voter approval through a specific ballot initiative. Thus far, no ballot initiatives for raising expenditure limits have even secured enough signatures to be put to a vote. Occasionally, local voters have approved accepting revenues from state or federal sources that would otherwise be subject to TABOR limits.

Partially as a result of TABOR limits, budgeting in Colorado is done incrementally, looking at increases from the base as a means of gauging what is feasible. These limits are particularly important for Medicaid, where spending has historically risen much faster than overall budget growth allowed each year by TABOR. Because of its growth rate, Medicaid is viewed as a limit to flexibility in financing other state activities. Consequently, there is great emphasis on finding savings in the program and little emphasis on expanding it.
Setting the Policy Context

Overview of the State’s Health Agenda

Colorado is interested in innovations in health care, particularly on an incremental basis, but this interest must be understood in the context of a fiscally conservative political environment. Innovations that cost little or actually save the state money are highly prized.

Only a short time ago, Colorado attempted a broad-scale reform of its health care system. In 1992, the Colorado General Assembly directed the Romer administration to study a proposal for universal health insurance called ColoradoCare. The governor established the Health Care Reform Initiative office, which produced a feasibility study of ColoradoCare. The proposal called for income- and payroll-tax financing and a single, government-run purchasing cooperative. These two features drew much fire, and the full proposal was never introduced as legislation. In 1994, the legislature instead enacted private insurance reforms, as discussed below.

The Colorado legislature gives considerable attention to Medicaid, but largely with an eye to keeping it from growing ever larger. Expansions of health insurance coverage are more likely to come outside of Medicaid to avoid expanding entitlement to a generous benefit package. Hence, Colorado has several state-only programs and initiatives, including, for example, the newly enacted Children’s Basic Health Plan (CBHP) and the long-standing Old Age Pension (OAP) program. Many of these programs are quite small, however. The challenge for the state seems to be to achieve savings in Medicaid and direct
some of those dollars to health programs that avoid the eligibility and benefit constraints of Medicaid. Expansion of Medicaid managed care is a high priority for the state as a means to achieve program savings. In long-term care, Colorado views its Medicaid home and community-based care waivers as successfully holding down costs.

State Health Care Indicators

Indicators of health status offer a picture of a population that varies from the national average in some key areas. The share of smokers and the percentage of low birth-weight births are slightly above national averages, but infant mortality and premature death rates are lower than those for the United States as a whole. The incidences of violent crimes and reported AIDS cases are substantially lower in Colorado than they are nationwide, which relieves the state of some major problems facing other areas. Overall, Colorado’s population is younger than the national average, limiting the higher costs associated with an aging population (table 1).

Health Care Spending and Coverage

The proportion of uninsured in Colorado, at 14 percent, is not as far below the national average of 15.5 percent as might be expected given the state’s booming economy. Employer-sponsored insurance is relatively prevalent in Colorado, but the reason the percentage of uninsured is still relatively high seems to be because of the small proportion of the population covered by Medicaid. At 5.9 percent, participation by the nonelderly population in Medicaid is less than half the national average of 12.2 percent and lowest among all the states (table 1). (These percentages represent the proportion of persons covered by Medicaid and no other form of insurance during 1994–95. In Colorado, the percentage of the nonelderly population that received Medicaid coverage in 1995, regardless of whether they were also covered by another form of insurance at another point during the year, approached 10 percent.)
State Health Programs

In Colorado, three agencies are responsible for most health programs. The Department of Health Care Policy and Financing administers Medicaid and a number of state-only health programs. The department was created in 1994 by merging several health care programs and activities, including Medicaid, the Health Data Commission (no longer in existence), and health policy functions of the governor’s office, into a single department. Medicaid was removed from the Department of Social Services, which was renamed the Department of Human Services. The Department of Human Services is responsible for overseeing mental health and developmental disabilities programs, managing the decentralized intake system that determines eligibility for long-term care services, managing eligibility determination for Medicaid in general, and overseeing the Old Age Assistance programs that often supplement Medicaid long-term care services. The Department of Public Health and Environment is responsible for public health programs, including family and community health services and disease control and prevention services. A fourth agency, the Department of Regulatory Agencies, handles insurance regulation.

Colorado was described by one state official as “the experiment” in devolution of public programs to localities, particularly in the area of welfare. The official predicted that under a scenario of Medicaid block grants, the state would likely devolve many of the rules on eligibility and benefits to counties. At this time, however, many of Colorado’s public expenditures are highly controlled at the state level. This is particularly true for Medicaid and for some of the state-only programs that supplement it. Modest local cost sharing is required of some programs. The intake process for determining general Medicaid eligibility and qualification for long-term care services takes place at the local level, although the rules and protocols are developed by the Department of Human Services. Given this shared state-local responsibility, it
is not clear how much variation in eligibility determination exists across the state. In the area of public health, local units operate fairly independently of the state and rely a great deal on local taxes.

**Medicaid**

In 1995, as shown in table 2, Medicaid represented 18.2 percent of state general fund expenditures, up from 10.5 percent in 1990. With a growth rate of more than 20 percent annually from 1990 to 1995 (both general fund and total expenditures), Medicaid was the fastest growing major public expenditure; its growth rate was more than double that for all general fund spending. It should hardly be surprising, then, that Medicaid is a major concern of state legislators, particularly with Colorado's constitutionally mandated limits on expenditure growth. Medicaid spending directly reduces the state's ability to raise its spending in other areas, a circumstance noted by many of those interviewed.

Colorado's Medicaid program is quite limited compared with those of other states. For example, Colorado has no medically needy program, and for the population under age 65 the state covers only the required groups. Some expansions, such as eliminating asset tests for children and adults, have been debated but not adopted. Colorado has expanded coverage for the elderly slightly beyond what is required; in particular, it covers persons with incomes up to 300 percent of the Supplemental Security Income (SSI) level for nursing home care and the home and community-based care waiver. This optional eligibility category offers greater protection than the mandated minimum but substantially less than that afforded under a medically needy program.

Between 1990 and 1992, Medicaid expenditures grew 33.5 percent per year to a level of more than $1 billion. Growth was particularly high in 1990 as a result of an expansion in children's coverage. Between 1992 and 1995, expenditures grew at a much lower average annual rate of 15.3 percent, reaching $1.57 billion. The decline was particularly dramatic in 1995. Colorado's growth rates in both periods exceeded that for the United States as a whole. From 1992 to 1995, the average annual rate of growth was more than 50 percent higher than that for the country overall (table 3).

The substantial deceleration in Colorado's Medicaid expenditure growth after 1992 occurred in all major expenditure categories. The most notable drop-off was in disproportionate share hospital (DSH) spending growth. DSH expenditures rose from just $4 million in 1990 to $120.8 million in 1992, for an average annual growth rate of 450 percent. Growth in the DSH program continued from 1992 to 1995, although at a much reduced rate of 43 percent per year. Throughout the first half of the decade, particularly from 1990 to 1992, acute care spending rose faster than long-term care spending in Colorado. The considerable increase in spending on children and adults from 1990 to 1992
coincides with the rapid increase in acute care expenditures, as these groups are primarily users of acute care services (table 3).

In 1995, acute care benefits constituted 43 percent of Medicaid expenditures in Colorado, and long-term care benefits accounted for 31 percent. The remaining expenditures were DSH payments (23 percent) and administration (3 percent). The DSH proportion in Colorado was substantially higher than the national average of 12 percent.

Another way to compare expenditures in Colorado with national spending is on a per recipient basis. In 1995, Colorado’s expenditures per elderly recipient and blind or disabled recipient were lower than the national averages, whereas per recipient expenditures for children and adults were higher than those for the United States as a whole (table 4). In the aggregate, Colorado’s Medicaid spending per participant is just below the national average. However, the number of participants as a share of the population is lower in Colorado than in other states.

<table>
<thead>
<tr>
<th>Program</th>
<th>State General Fund Expendituresa</th>
<th>Total Expendituresb</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>$2,577</td>
<td>$3,884</td>
</tr>
<tr>
<td>Medicaid</td>
<td>270</td>
<td>708</td>
</tr>
<tr>
<td>% of Total</td>
<td>(10.5)</td>
<td>(18.2)</td>
</tr>
<tr>
<td>Corrections</td>
<td>153</td>
<td>290</td>
</tr>
<tr>
<td>% of Total</td>
<td>(5.9)</td>
<td>(7.5)</td>
</tr>
<tr>
<td>K–12 Education</td>
<td>1,081</td>
<td>1,548</td>
</tr>
<tr>
<td>% of Total</td>
<td>(41.9)</td>
<td>(39.9)</td>
</tr>
<tr>
<td>AFDC</td>
<td>35</td>
<td>42</td>
</tr>
<tr>
<td>% of Total</td>
<td>(1.4)</td>
<td>(1.1)</td>
</tr>
<tr>
<td>Higher Education</td>
<td>518</td>
<td>643</td>
</tr>
<tr>
<td>% of Total</td>
<td>(20.1)</td>
<td>(16.6)</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>520</td>
<td>653</td>
</tr>
<tr>
<td>% of Total</td>
<td>(20.2)</td>
<td>(16.8)</td>
</tr>
</tbody>
</table>


a. State spending refers to general fund expenditures plus other state fund spending for K–12 education.
b. Total spending for each category includes the general fund, other state funds, and federal aid.
c. States are requested by the National Association of State Budget Officers (NASBO) to exclude provider taxes, donations, fees, and assessments from state spending. NASBO asks states to report these separately as “other state funds.” In some cases, however, a portion of these taxes, fees, etc., is included in state spending because states cannot separate them. Colorado reported other state funds of $11 million in 1990 and $1 million in 1995.
d. Total Medicaid spending will differ from data reported on the HCFA 64 for three reasons: first, NASBO reports on the state fiscal year and the HCFA 64 on the federal fiscal year; second, states often report some expenditures, e.g., mental health and/or mental retardation, as other health rather than Medicaid; third, local contributions to Medicaid are not included but would be part of Medicaid spending on the HCFA 64.
e. This category includes all remaining state expenditures (i.e., environmental projects, transportation, housing, and other cash assistance programs) not captured in the five listed categories.
Table 3  Medicaid Expenditures by Eligibility Group and Type of Service, Colorado and United States ($ in Millions)

<table>
<thead>
<tr>
<th></th>
<th>Colorado</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Expenditures</td>
<td>Average Annual Growth</td>
</tr>
<tr>
<td>Total</td>
<td>$577.1</td>
<td>$1,028.4</td>
</tr>
<tr>
<td>Benefits</td>
<td>$536.5</td>
<td>$871.9</td>
</tr>
<tr>
<td>Benefits by Service</td>
<td>254.8</td>
<td>493.7</td>
</tr>
<tr>
<td>Acute Care</td>
<td>281.7</td>
<td>378.2</td>
</tr>
<tr>
<td>Long-Term Care</td>
<td>$536.5</td>
<td>$871.9</td>
</tr>
<tr>
<td>Elderly</td>
<td>$175.8</td>
<td>$244.5</td>
</tr>
<tr>
<td>Acute Care</td>
<td>34.5</td>
<td>49.3</td>
</tr>
<tr>
<td>Long-Term Care</td>
<td>141.3</td>
<td>195.2</td>
</tr>
<tr>
<td>Blind and Disabled</td>
<td>$227.2</td>
<td>$323.9</td>
</tr>
<tr>
<td>Acute Care</td>
<td>97.1</td>
<td>155.8</td>
</tr>
<tr>
<td>Long-Term Care</td>
<td>130.1</td>
<td>168.1</td>
</tr>
<tr>
<td>Adults</td>
<td>$54.7</td>
<td>$138.4</td>
</tr>
<tr>
<td>Children</td>
<td>$78.8</td>
<td>$165.2</td>
</tr>
<tr>
<td>DSH</td>
<td>$4.0</td>
<td>$120.8</td>
</tr>
<tr>
<td>Administration</td>
<td>$36.5</td>
<td>$35.7</td>
</tr>
</tbody>
</table>

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.
Table 4  Medicaid Expenditures per Enrollee by Eligibility Group, Colorado and United States

<table>
<thead>
<tr>
<th>By Group</th>
<th>Colorado</th>
<th></th>
<th></th>
<th></th>
<th>United States</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Spending per Enrollee</td>
<td>Average Annual Growth</td>
<td></td>
<td></td>
<td>Spending per Enrollee</td>
<td>Average Annual Growth</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$2,237</td>
<td>$2,642</td>
<td>$3,176</td>
<td>8.7%</td>
<td>6.3%</td>
<td>$2,397</td>
<td>$2,729</td>
</tr>
<tr>
<td>Elderly</td>
<td>$5,315</td>
<td>$7,059</td>
<td>$8,493</td>
<td>15.2%</td>
<td>6.4%</td>
<td>$6,839</td>
<td>$8,422</td>
</tr>
<tr>
<td>Cash</td>
<td>3,225</td>
<td>4,318</td>
<td>5,297</td>
<td>15.7%</td>
<td>7.0%</td>
<td>3,329</td>
<td>4,017</td>
</tr>
<tr>
<td>Noncash</td>
<td>10,241</td>
<td>13,520</td>
<td>16,028</td>
<td>14.9%</td>
<td>5.8%</td>
<td>10,377</td>
<td>12,192</td>
</tr>
<tr>
<td>Blind and Disabled</td>
<td>$6,877</td>
<td>$7,764</td>
<td>$7,461</td>
<td>6.3%</td>
<td>-1.3%</td>
<td>$6,378</td>
<td>$7,320</td>
</tr>
<tr>
<td>Cash</td>
<td>6,728</td>
<td>7,743</td>
<td>7,385</td>
<td>7.3%</td>
<td>-1.6%</td>
<td>4,969</td>
<td>5,927</td>
</tr>
<tr>
<td>Noncash</td>
<td>7,098</td>
<td>7,795</td>
<td>7,573</td>
<td>4.8%</td>
<td>-1.0%</td>
<td>12,047</td>
<td>12,574</td>
</tr>
<tr>
<td>Adults</td>
<td>$958</td>
<td>$1,656</td>
<td>$1,814</td>
<td>31.5%</td>
<td>3.1%</td>
<td>$1,301</td>
<td>$1,518</td>
</tr>
<tr>
<td>Children</td>
<td>$675</td>
<td>$971</td>
<td>$1,247</td>
<td>19.9%</td>
<td>8.7%</td>
<td>$770</td>
<td>$931</td>
</tr>
</tbody>
</table>

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.
Department of Public Health and Environment

Colorado’s Department of Public Health and Environment, with a budget of $203 million in FY 1996-97, administers an array of programs that target the health of populations at large as well as the health of low-income individuals. Within the department’s Office of Health, programs with a population orientation include disease control, epidemiology, and prevention. The Division of Family and Community Health Services—the largest division in the Office of Health in terms of funding—focuses primarily on the health of vulnerable individuals. Programs in this division include maternal and child health, family planning, migrant health, and the Women, Infants, and Children (WIC) nutrition program.

The department is very dependent on federal funds for its operations; reportedly, the legislature is reluctant to support any programs not attached to federal monies. However, recent departmental efforts to gain greater legislative support, combined with a robust state economy, resulted in the department’s largest ever general fund increase—20 percent—for FY 1997-98. The actual infusion of new dollars is rather small, as general fund support comprised only 8 percent of the department’s total budget in FY 1996-97. In contrast, the percentage of funding derived from federal sources is striking and has increased significantly for the Office of Health—from 74 percent in FY 1990-91 to 85 percent in FY 1996-97. The programs that receive the largest amount of federal monies are the WIC program and another supplemental nutrition program, totaling $75 million in federal funds in FY 1996-97.¹

Mental Health and Developmental Disabilities

Oversight of mental health and developmental disabilities programs resides in the Department of Human Services. The department’s Health and Rehabilitation Programs Office houses the Division of Mental Health Services and the Division of Developmental Disabilities Services. Localities are responsible for community-based services; the state’s role in service provision is largely limited to institutional care.

The Division of Mental Health Services operates through 17 community mental health centers (CMHCs). The CMHCs are the entry points for state-sponsored mental health services and are responsible for providing or contracting for a range of services in their area. In FY 1995-96, 43 percent of the $136 million in funding for the CMHCs was from Medicaid; this share has continued to increase over time. The next largest category is state funds (excluding Medicaid matching funds), which comprised 23 percent of revenues.²

Responsibility for the provision of services to persons with developmental disabilities is primarily held by local jurisdictions. County or multi-county community centered boards (CCBs) are responsible for eligibility determina-
tion, service plan development, and arrangement for, purchase of, or direct delivery of services. The CCB system began in 1964 and today consists of 20 private nonprofit organizations that serve as the single entry point into the long-term care system for persons with developmental disabilities. Approximately 90 percent of developmentally disabled persons are covered by Medicaid, and in 1995, 62 percent of the $147 million in total revenues for the CCBs originated from Medicaid.\(^3\)
Assessing the New Federalism: Potential State Responses to Additional Flexibility and Reduced Funding

Many Colorado policymakers have expressed to the federal government a strong desire for increased flexibility for health and social services programs. The Colorado legislature’s resistance to federal constraints is apparent in its dislike of the entitlement nature of Medicaid, specifically its mandatory benefits and eligibility rules. At one point the legislature voted to withdraw from the Medicaid program entirely unless the federal government granted a comprehensive waiver, but Governor Romer vetoed the legislation. Recognition of the importance of federal contributions led the state to abandon that strategy. Rather than maximize federal contributions through Medicaid eligibility expansions, Colorado uses state-only programs where feasible to ensure flexibility and limit entitlement to new benefits. For example, even before the State Children’s Health Insurance Program was passed at the federal level, the state developed a children’s insurance initiative outside of Medicaid. The state’s heavy reliance on Medicaid home and community-based care waivers to deliver long-term care services is another effort to maximize flexibility.

The general philosophy of Colorado toward health care for the poor seems to be one of providing a floor while avoiding the establishment of new entitlements. Colorado’s minimalist approach stems less from a fear that it will become a welfare magnet—particularly since it is less generous than many states—than from a desire to limit the role of government in the lives of its citizens.
There is some sympathy, however, for those who are uninsured and ineligible for health benefits extended through welfare—especially children. Indeed, Colorado has had serious debates about trying to expand health coverage to all citizens, and it has undertaken a number of interesting but limited state-only programs. These efforts are tempered by the view of some that emergency health care is available to those with serious health problems and that such care can serve as a sufficient safety net.
Despite its limited nature in Colorado, the Medicaid program is still the main vehicle for providing health coverage to the low-income population. For some uninsured Coloradans not eligible for Medicaid, health care is partially reimbursed through the Colorado Indigent Care Program (CICP). Children not otherwise covered may be eligible for the Child Health Plan (CHP, recently scheduled to be replaced by the Children’s Basic Health Plan). Other state programs target specific populations, such as the Old Age Pension program, or specific health problems, such as the Colorado Prenatal Plus program. In FY 1996, about 15 percent of Coloradans received health care services financed either through Medicaid or other publicly funded programs. In 1995, an estimated 540,000 Coloradans were uninsured, of whom 150,000 were children. Many must rely on charity care at hospitals and clinics because they cannot afford to pay out of pocket.

Medicaid Eligibility

The number of persons covered by Colorado’s Medicaid program in 1995 was 368,500 (table 5). (The Department of Health Care Policy and Financing reported Medicaid enrollment of 280,578 in 1995. This figure represents the average monthly case load or “full-time equivalent” enrollees, and thus is lower than total enrollment shown in table 5 because not all Medicaid enrollees remain in the program for an entire year.) The 1995 number
<table>
<thead>
<tr>
<th>By Group</th>
<th>Colorado Enrollment</th>
<th>Average Annual Growth</th>
<th>United States Enrollment</th>
<th>Average Annual Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>239.9</td>
<td>330.0</td>
<td>368.5</td>
<td>17.3%</td>
</tr>
<tr>
<td>Elderly</td>
<td>33.1</td>
<td>34.6</td>
<td>39.5</td>
<td>2.3%</td>
</tr>
<tr>
<td>Blind and Disabled</td>
<td>33.0</td>
<td>41.7</td>
<td>59.9</td>
<td>12.4%</td>
</tr>
<tr>
<td>Adults</td>
<td>57.1</td>
<td>83.5</td>
<td>92.6</td>
<td>20.9%</td>
</tr>
<tr>
<td>Cash</td>
<td>47.2</td>
<td>58.0</td>
<td>47.6</td>
<td>10.8%</td>
</tr>
<tr>
<td>Noncash</td>
<td>9.9</td>
<td>25.5</td>
<td>45.0</td>
<td>60.5%</td>
</tr>
<tr>
<td>Children</td>
<td>116.6</td>
<td>170.1</td>
<td>176.5</td>
<td>20.8%</td>
</tr>
<tr>
<td>Cash</td>
<td>97.7</td>
<td>114.3</td>
<td>95.6</td>
<td>8.1%</td>
</tr>
<tr>
<td>Noncash</td>
<td>18.9</td>
<td>55.9</td>
<td>80.9</td>
<td>72.0%</td>
</tr>
</tbody>
</table>

Source: The Urban Institute, 1997. Based on HCFA 2082 data.
represents a substantial increase from 239,900 enrollees in 1990. Most of the growth during this period occurred between 1990 and 1992 among nondisabled adults and children, largely as a result of federally mandated eligibility expansions. The average annual growth rate in enrollment for all eligibility categories was 17.3 percent from 1990 to 1992, versus 3.7 percent from 1992 to 1995. Medicaid enrollment related to Aid to Families with Dependent Children (AFDC) has been slowly declining (by about 6 percent per year from 1992 to 1995), chiefly because of the strong economy and the resulting lower AFDC rolls. For the period 1992 to 1995, declines in the AFDC population were offset somewhat by expansion of coverage for the disabled and non-AFDC low-income pregnant women and children (Baby Care/Kids Care program). Yet growth in these categories is slowing as well. In fact, the Baby Care/Kids Care population has declined sharply in recent years. The total number of Medicaid enrollees is projected to rise at a rate of less than 1 percent per year from 1995 to 1998.5

Eligibility Categories

Although the percentage of Colorado’s population that is uninsured is lower than the national average, the limited coverage under Medicaid suggests that the low-income population remains at considerable risk. Colorado essentially offers no expanded eligibility for acute care beyond federally mandated groups and no medically needy program allowing persons to spend down to eligibility. (As mentioned above, the state does cover the optional eligibility group of those with incomes less than 300 percent of the SSI limit for long-term care services.) The income cutoffs for non-AFDC pregnant women and infants (Baby Care/Kids Care) and children up to age six are 133 percent of the federal poverty level, per federal requirements. As mandated, children through age 18 born after September 30, 1983, in households with incomes up to 100 percent of the federal poverty level are also covered. Emergency care is provided for noncitizen aliens who have not established legal residence.

A few changes in Medicaid eligibility were made in the 1997 legislative session. They include authorization to develop buy-in programs for both former AFDC/Temporary Assistance for Needy Families (TANF) recipients and disabled Medicaid recipients, which will extend Medicaid coverage indefinitely for these groups after they return to work. A number of interviewees expressed a belief that until the effects of these changes are fully understood, further expansions are unlikely.

Eligibility Determination and Enrollment

The Department of Health Care Policy and Financing (HCPF) identified numerous areas of concern regarding Medicaid eligibility determination. First, the automated eligibility system for Medicaid is 20 years old and no longer adequate to the task. Partly as a result, the current average eligibility determination processing time is at or slightly above the allowable maximum. Second,
under welfare reform, the eligibility standards and enrollment processes of Medicaid and TANF are separate and different. This delinking is expected to create problems in identifying eligible recipients and enrolling them at the county level. In addition, HCPF is concerned that some clients will inappropriately lose Medicaid eligibility when disenrolled from TANF. The incentives counties face to reduce welfare rolls may take precedence over efforts to enroll or retain eligible persons in Medicaid.

In response to these issues, the state is developing a new automated eligibility system, the Colorado Benefits Management System (CBMS). Under the CBMS, Medicaid will have a separate eligibility system that will have the capability to interface with eligibility systems for other programs such as TANF and food stamps. County-level variation in Medicaid participation could still be an issue, however, if a county’s intake process falls short of identifying all those who might be eligible. While development of the CBMS is under way, an interim strategy to speed up the eligibility process that is likely to be adopted is allowing eligibility determinations as well as enrollment at sites other than county human services offices. Some concern was expressed that allowing enrollment at other sites, such as clinics, might conflict with the provision of full information about managed care options to enrollees, because some sites may have linkages with particular health maintenance organizations (HMOs). However, use of an enrollment broker should mitigate this problem.

Other Public Financing Programs

In addition to standard Medicaid, HCPF oversees a number of state-only health care and special Medicaid programs. These programs include the Colorado Indigent Care Program, the Child Health Plan/Children’s Basic Health Plan, the Medicaid transitional benefits program, the Old Age Pension program, school-based health care, and the Colorado Uninsurable Health Insurance Plan (CUHIP).

Colorado Indigent Care Program

CICP provides inpatient and outpatient coverage for uninsured residents of all ages with income below 185 percent of the federal poverty level and assets below a specified minimum. The program is essentially a means to reimburse providers for a fraction of the uncompensated care they provide while enhancing access to services for the uninsured. Unlike many other programs, CICP eligibility applications are processed at the provider level. Eligible patients are responsible for a copayment for each visit, but a ceiling is placed on total copayments in any one year. In FY 1996 there were 133,772 unduplicated CICP users with 574,096 visits to hospitals and clinics; about one-third of the users were children. The number of users represents a 40 percent increase over the past three years.
To participate in CICP, providers must deliver, at a minimum, charity care equivalent to 3 percent of revenues. They must also agree to provide at least $4 worth of charity care for every $3 of CICP funding they receive, making the theoretical CICP reimbursement 75 percent of costs. Most providers exceed this requirement and, in fact, are reimbursed much less than the cost of CICP patients. Before FY 1995, CICP reimbursed providers for about 20 percent of their costs, with funding for CICP hospitals generated through the Medicaid DSH program. In 1995, outstate facilities—that is, non-Denver facilities—were added to the DSH program, which earned additional federal matching funds. As a result, reimbursement rose to about 29 percent of costs.

Providers have voiced several complaints about CICP. In addition to stressing the inadequacy of the reimbursement level, they view eligibility determination as an administrative burden, and they believe that funds are poorly distributed geographically. For example, University Hospital in Denver and Denver Health and Hospital Authority (DHH) accounted for more than half of all CICP funding in FY 1996.

**Child Health Plan/Children’s Basic Health Plan**

Prior to 1998, the CHP covered outpatient services for low-income children under age 13 in rural areas. The program was further restricted to those whose family incomes fell under 185 percent of the federal poverty level and who did not qualify for Medicaid. (The income requirement for CHP was less stringent than the state’s Medicaid program, as described above.) To participate, families had to pay an annual premium of $25 per child up to a family maximum of $150 per year. Approximately 6,200 children were enrolled in the program in 1997.

Under the recently passed House Bill 97-1304, the CHP will be merged with CICP funding for children and renamed the Children’s Basic Health Plan. The new program will offer inpatient and outpatient services for both rural and urban children. It will cover a specified number of children up to age 18 with family incomes under 185 percent of the federal poverty level. As authorized, the program does not create an entitlement, so enrollment is subject to available funding. It is expected that 33,000 to 40,000 children will participate by year three of the program, when the program is fully phased in. The state expected to begin enrollment in spring 1998.

Premiums will be assessed on a sliding scale based on income. Families whose incomes exceed the eligibility limit can buy into the program at full cost, estimated at $617 to $725 per child annually. Other new funds to support CBHP will come from savings derived from reimbursement caps on administrative costs of nursing homes and some of the savings from expanding Medicaid managed care. Although the state originally planned to apply for a Medicaid Section 1115 waiver to obtain federal matching funds for the CBHP, it has applied and received approval for federal funding under Title XXI (the State Children’s Health Insurance Program).
HCPF will contract with managed care plans for capitated service delivery to CBHP participants. Under limited circumstances, the program will offer a fee-for-service arrangement. It will also buy into comparable private insurance coverage for children who meet the eligibility criteria and have parents whose employers offer coverage for dependents.

**Medicaid Transitional Benefits Program**

AFDC/TANF recipients are currently provided Medicaid transitional benefits for up to 12 months after their welfare eligibility ends. Under the recently passed Senate Bill (SB) 97-120, former welfare recipients will be eligible to extend coverage beyond the initial 12 months through Transition Plus, an HMO look-alike with more limited benefits than the straight transition program. Premiums and fees will be based on income. Wraparound benefits will be available as a purchase option under both programs for former AFDC/TANF recipients whose new jobs provide less generous benefits than Medicaid. Eligibility and implementation rules for Transition Plus had yet to be written at the time of the site visit. Enrollment in the new program is slated to begin on January 1, 1999.

**Old Age Pension Program**

Begun in 1937, the OAP program is funded solely by the state and is written into its constitution. The program provides cash grants to needy individuals over age 60; it has a high income threshold for participation. The OAP program is funded out of the 2 percent sales tax. Funds remaining after pensions are paid (the assistance payment portion of OAP) are used to extend the range of state-financed Medicaid benefits, except long-term care, to noninstitutionalized OAP recipients who do not qualify for federally matched Medicaid coverage. This Health and Medical Care Fund is limited to $10 million. OAP covers legal immigrants as well as citizens; in fact, a disproportionate number of its beneficiaries are immigrants.

**School-Based Health Care**

Under SB 97-101, school districts will be allowed to receive reimbursement for eligible services provided to Medicaid enrollees. The schools will be encouraged to spend up to 30 percent of the federal matching funds they receive on services for uninsured children. Participation by schools is voluntary.

**Colorado Uninsurable Health Insurance Plan**

CUHIP is a nonprofit entity that offers health insurance to individuals who have been denied affordable coverage because of preexisting medical conditions. Established by the Colorado state legislature, CUHIP receives supplemental funding from the state. To further cover the costs of the program, persons insured under CUHIP pay premiums higher than those paid for standard health insurance.
Insurance Reforms

Colorado implemented substantial reforms of its small-group market on January 1, 1995, pursuant to a 1994 law that the legislature hoped would reduce costs and expand access to health insurance for small employers. The key provisions were guaranteed issue, guaranteed renewal, limits on preexisting condition exclusions, and modified community rating. The overall intent of the law was to make it more difficult for insurers to refuse to sell to any particular employment-based group and to increase pooling of health risks. The law applies to all health insurance products—indemnity and managed care alike—sold to firms with 1 to 50 employees. (Colorado law requires that “business groups of one”—defined as proprietors, the self-employed, or a sole employee, including household employees (nannies and domestics)—be permitted to purchase health insurance in the small-group market.) The law also applies to all insurers—indemnity carriers, HMOs, and Blue Cross/Blue Shield—and is enforced by the Department of Insurance, which has oversight authority on all three types of insurers. The commissioner of insurance is appointed by the governor and confirmed by the state senate.

Guaranteed issue in Colorado means that insurers must offer at least two products—standard and basic, which differ mostly in their cost-sharing provisions—to all small groups that seek health insurance. As of July 1, 1997, this provision was superseded by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), which requires guaranteed issue for all products sold to small groups in all states.

Guaranteed renewal, as legislated by Colorado and required by HIPAA, means that an insurer must offer to continue coverage of a currently insured group—that is, the policy cannot be summarily canceled because of claims experience or a change in the health status of the group members. Insurers can increase the premium charged at renewal, however.

Colorado limits exclusions from coverage of preexisting conditions to six months (the waiting period), and then only for conditions that were treated or the subject of a medical consultation in the six months before coverage began (the look-back period). This provision is more generous to consumers than the preexisting condition restriction in the federal HIPAA, which requires states to have at most a 12-month waiting period. Like HIPAA, Colorado has a credit-for-prior-coverage provision, which means that continuous time spent covered under one’s previous plan must count toward preexisting condition exclusions imposed in any new plan. Thus, Colorado has already provided for group-to-group portability.

Pure community rating would entail charging all insured persons the same premium for the same benefit package. Most states use modified community rating (i.e., they allow specific and limited deviations from identical pricing). Colorado phased in its modified community rating approach slowly, allowing
variation of ±20 percent in 1995 and 1996 and ±10 percent in 1997 and beyond. These rate bands are relatively tight compared with those in the 46 other states that have adopted premium controls of some kind in the past six years. Colorado also restricts the different factors that insurers may use to vary (rate) groups’ premiums to age, family size, and geographic region.

Like most states, Colorado has taken fewer steps to reform the individual health insurance market. Before HIPAA’s implementation in 1998, the only substantive reform was a guaranteed renewal provision that was passed in 1996 with an effective date of January 1, 1997. Yet Colorado law does provide that all premiums for individual policies must be increased at the same annual rate. This provision protects bad risks somewhat and prevents durational or tiered rating, a technique used for decades by indemnity insurers nationwide. Most small groups and individuals, if underwritten carefully and risk-selected in the first place, as most were before states passed reform laws, are likely to have deteriorating health status and claims experience over time. Durational rating increases the premiums of the long-insured to encourage them to seek other insurers, on the theory that if insurers did not do this, they would have to cover the health expenses of the inevitable “bad” year. In 1997 Colorado also began permitting “business groups of one,” defined above, to purchase insurance in the individual market if they preferred this to the small-group market. Some people wanted this privilege to avoid benefit mandates that Colorado has imposed on the small-group market and to obtain favorable (experience-rated) rates. Agents in Colorado also receive much larger commissions for individual market policies than for “business groups of one” policies, so they encourage their clients to buy through the individual market as well.
Like most of the rest of the country, Colorado is experiencing a wide range of changes in the health care market that are altering the nature of financing and delivery of care. Changes in both the public and the private insurance markets, in particular, are continuing to have important effects on the health care delivery system.

Changes in the Health Care Market and Their Impact on Access for Low-Income Populations

In part because of its insurance reform efforts, Colorado has achieved one of the highest percentages of nonelderly population covered by private, employer-sponsored insurance in the nation—72.2 percent in 1994–95 (table 1). Private insurance coverage, and how the state has regulated the insurance market, is very important for the low-income population. While the insurance market is very competitive and works smoothly, two unresolved issues are of particular note. First, the largest insurer in the state, Blue Cross/Blue Shield of Colorado, is converting to for-profit status, and proceeds from the sale of the health plan will help create a nonprofit foundation to serve the health needs of Colorado’s citizens. The second issue relates to the mandating of mental health parity.

In response to Blue Cross/Blue Shield of Colorado’s decision to convert to for-profit status, the legislature passed Senate Bill 100 in 1996, specifying the conversion process for health plans and giving the commissioner of insurance final power to approve a conversion plan. In addition to two rounds of public hearings—one round on the structure and governance of the new nonprofit
foundation and the second on the fair market value of the health plan’s assets to be transferred to the new nonprofit foundation—the bill requires the foundation to serve the health needs of Colorado’s citizens.

In the Blue Cross/Blue Shield case, the first round of hearings was completed in September 1997, and the second round was to be completed early in 1998. There is considerable political support for the foundation to focus on children’s health insurance coverage, but no final decision has been made. Controversy is expected about what the fair market value is and how much should be transferred how fast to the new foundation. The commissioner of insurance is expected to make a decision on the Blue Cross/Blue Shield conversion by mid-1998. A companion bill giving the attorney general the same kind of responsibilities and power over nonprofit hospital conversions was defeated in 1997 but was enacted in a different form in the 1998 legislative session.

Another issue in Colorado’s insurance market for the near future concerns mental health parity. A 1997 law added full parity (prohibition of differential limits for mental and physical health care services) for eight biologically based mental conditions. Colorado had previously mandated 45 mental health inpatient days and $1,000 for mental health outpatient visits at no more than a 50 percent copayment. The move to parity, plus the continued narrowing of rate bands in the small-group market, could reverse some of the favorable premium experiences of the past few years. Still, with the competitive environment being what it is—80 carriers and 21 HMOs in total (seven are new as of 1997, and four of these are provider-sponsored)—other efficiencies will be aggressively sought to pay for the increased mental health benefits for the employed population and its dependents without significant premium increases, at least in the short run. Potentially much more costly than mental health parity, point-of-service products are offered by about half of the HMOs voluntarily, mostly because employers in the marketplace demand it.

The Colorado Health Care Market

Informed estimates are that as much as 80 percent of the privately insured market in Colorado is enrolled in either HMOs or preferred provider organizations (PPOs). As elsewhere, this situation has put considerable pressure on providers, especially hospitals, to reduce prices and become more efficient.

The Hospital Market

Mergers and joint ventures to reduce redundancies and to achieve economies of scale in purchasing, administration, and even patient care are commonly employed tools of efficiency that have been used in Colorado. Local hospitals that fear for their survival have merged with national hospital systems to take advantage of volume purchasing and reductions in administrative costs. Six major hospital systems own numerous hospitals in Colorado: Columbia/
HCA; HealthONE; Sisters of Charity of Leavenworth, Kansas; Sisters of Charity Health Care Systems of Cincinnati, Ohio; PorterCare; and Lutheran Health Systems. All have paired off to form joint ventures for their Colorado hospitals, so there are really only three independent hospital systems in Colorado: Columbia/HealthONE, Centura (PorterCare and Sisters of Charity, Cincinnati), and Exempla (Lutheran and Sisters of Charity, Leavenworth). Health care entities in general are becoming more integrated, as physician groups and hospitals form networks and enter into joint purchasing and service provision agreements.

**Competition in the Health Insurance Market**

The Colorado Department of Insurance facilitates competition in health insurance markets by preparing and releasing a report each year on premium rates charged by all small-group insurers in the Denver area for six standardized plans (standard and basic for indemnity, HMOs, and PPOs). The first report was published in April 1995, three months after the small-group reform law was implemented. That year, variations across companies for identical products were as large as 350 percent for indemnity insurers and 180 percent for HMOs. By 1997, the largest variation had increased to 380 percent for indemnity and 220 percent for HMOs, but average HMO premiums fell each year (3.4 percent between 1995 and 1996 and 4.6 percent between 1996 and 1997), while average PPO and indemnity premiums increased only 4.2 percent and 6.5 percent per year, respectively. This experience is much better than has been observed nationally in the small-group market. Thus, it is reasonable to infer that the Colorado small-group insurance market is performing the way a highly competitive market is expected to perform. The widening absolute range in premiums probably reflects adverse selection in the “losing” plans, and more than likely the highest cost plans will continue to lose market share.

As further evidence of Colorado’s competitive health plan market, the leading small-group player in 1993, Kaiser, saw its 12.8 percent market share decline to 8.7 percent by 1996 despite a 2.4 percent drop in premiums. In 1997, only five insurers had more than 5 percent of the small-group market, and the largest (Employer’s Health) had only 13 percent. It is too early to tell which managed care companies will dominate Colorado’s health plan market in the future, but it appears that competition will be vibrant at least in the near term. Among Colorado’s insurance market observers, small-group reforms are given high marks for making the fruits of this health plan competition available to small employers.

**Regulation of Managed Care Plans**

Colorado has no substantial any-willing-provider laws, but there was significant political activity to protect pharmacists in the 1997 legislative session. Managed care in Colorado has matured and been accepted generally, especially among employers. The anti-managed care “backlash” seen elsewhere takes the form in Colorado not of trying to erase HMOs but of adopting a watchful, waiting approach.
Adequacy of Medicaid Hospital and Physician Reimbursement and Disproportionate Share Hospital Payments

Medicaid provider payment is not a divisive issue in Colorado because both hospitals and physicians, in general, consider payment rates to be adequate. The state’s DSH program has generated comparatively more charged discussion and debate.

Hospital Payment

Colorado implemented a prospective payment system based on diagnosis-related groups (DRGs) for Medicaid hospital inpatient services in the late 1980s. In 1990, the state lost a lawsuit brought by hospitals under the Boren amendment, which requires reimbursement sufficient to cover the full cost of an economically and efficiently operated facility. As a result, the state not only raised payment levels but also switched from a generic DRG system to a payment system based on Colorado hospital data. Although these changes in the payment system were expected to create some big winners and losers, hospitals generally have not expressed concern regarding rates.

Data from the American Hospital Association indicate that Medicaid hospital reimbursement rates as a percentage of hospitals’ costs have increased considerably in Colorado, from 67 percent in 1989 to 89 percent in 1993. Consequently, although still below the national average of 93 percent, hospital payment rates are considered adequate, and no new Boren amendment suits have been brought against the state. Before the Boren amendment was repealed by the Balanced Budget Act of 1997, state officials predicted that a repeal would not affect the level at which they set payment rates. They noted that overall payments to hospitals have already declined in recent years in Colorado (even though payments have grown as a percentage of costs).

Physician Reimbursement

Although the state is attempting to move a significant number of Medicaid enrollees into capitated managed care plans, 75 percent of enrollees’ physician services are still reimbursed on a fee-for-service basis. The state uses the Medicare relative-value scale system to reimburse physicians for evaluation and management services and has developed its own fee schedule for the remaining services. As of 1993, relative to the rest of the nation, the Medicaid program in Colorado paid roughly average rates. Since that time, the state increased reimbursement rates for both primary care and obstetrical services by 51 percent and 33 percent, respectively.

State Charity Care Reimbursement

Colorado has two main programs that reimburse community and teaching hospitals and community clinics for services provided to the uninsured—
the Colorado Indigent Care Program and the Medicaid DSH program. Both programs are funded largely through intergovernmental transfers (IGTs).

There are four categories of CICP recipients: Denver Health and Hospital Authority (DHH); University Hospital; specialty hospitals; and hospitals and clinics outside the Denver area. CICP providers received approximately $34 million in CICP reimbursements in 1996. With two exceptions, all funds are federally matched DSH dollars generated through the IGT program. State general revenues are used to generate the federal match for the University Hospital program and to fund the outstate clinics. Because the state keeps some of the revenue associated with the DSH program, some of those funds can be used to finance the outstate clinic component of CICP.

Four groups of hospitals receive DSH as well as CICP reimbursement: hospitals that provide “bona fide” contributions to the state to obtain federal matching funds; a number of specialty hospitals across the state; DHH; and University Hospital. These hospitals received roughly $36 million in DSH payments, net of IGTs, in FY 1996-97. DHH was the largest recipient of funds (almost 55 percent of the total), followed by University Hospital (37 percent).

The DSH program has also been a significant source of revenue for the state. Between FY 1993-94 and FY 1996-97, the state retained approximately $150 million of the $361 million in federal matching funds generated through the DSH program.

Despite the fact that Colorado is classified as a high DSH state, with an allotment of more than $300 million per year, it does not spend up to its limit. (The limit is high in part because of a large, one-time DSH expenditure in the year the limit was set.) Under present policy, the state cannot fund hospitals using all available DSH funds because of TABOR limits—IGTs count as state revenue, which is capped under TABOR. In the 1997 legislative session, DHH and University Hospital were actively involved in attempting to change the state method for generating DSH monies. The federal government approved a certification-of-uncompensated-expense proposal, which did not require a transfer of funds intergovernmentally, thus bypassing TABOR limits. The net benefit to DHH and University Hospital reportedly would have been several million dollars, and other DSH hospitals would have benefited as well. The proposal never went very far in the legislature, however, for two primary reasons. First, some hospitals are not government owned, so any change in the state DSH program would have increased general fund expenditures needed to generate the federal match for these hospitals (by an estimated $3 million). Second, in a state with a strong distaste for entitlement programs, legislators were uncomfortable obtaining more federal money, which might incite a program “feeding frenzy.” If this money were to dry up in the future, the state would then have to cut back or make up the difference. Despite the legislature’s reluctance to draw down additional federal DSH funds, respondents indicated that it may have to revisit the issue when purse strings are drawn tighter.
Medicaid Managed Care

The roots of Colorado’s Medicaid managed care program date back to 1974, when Rocky Mountain HMO began assuming full risk for voluntarily enrolled Medicaid beneficiaries on the Western Slope (a rural area of the state). Nearly a decade later, in 1983, the state began operating its Primary Care Physician (PCP) case management program under a Section 1915(b) freedom of choice waiver—one of the first such programs in the nation. The PCP program is statewide and is mandatory for AFDC/TANF and related beneficiaries and SSI recipients, excluding the dually eligible, foster children, and institutionalized persons. Participating physicians are paid a monthly case management fee of $4.70 in addition to fee-for-service payments. If an HMO is available in a recipient’s community, the recipient may opt for HMO enrollment instead of the PCP program.

Enrollment and Participation by Plan

In the early years of the 1915(b) waiver program and until fairly recently, the majority of eligible recipients participated in the PCP program rather than enrolling in an HMO. In 1993, 135,000 recipients were in the PCP program and 10,000 were enrolled in Rocky Mountain HMO, accounting, in total, for somewhat more than half of the state’s Medicaid population. Two interrelated factors accounted for low HMO enrollment—the lack of a mandate or strong incentives for Medicaid recipients to join an HMO, and insufficient interest by HMOs in Medicaid. HMOs doubted their ability to attract enough enrollees to spread risk adequately and thus were not enthusiastic about the Medicaid market. Rocky Mountain HMO’s sizable membership was the result of a long-standing custom among physicians on the Western Slope of requiring their Medicaid patients to join the HMO in order to be seen by them.

PCP and HMO enrollees continued to account for about half of the total Medicaid population as of mid-1997. What has changed since 1994, however, is a dramatic shift of recipients from the PCP program into HMOs. As of May 1997, approximately 70,000 recipients were enrolled in five HMOs, and 60,000 remained in the PCP program. Most HMO enrollees are in the Denver metro area. This transformation occurred nearly “overnight” as a result of increased participation by HMOs in the Medicaid program. Increased participation was prompted by at least three factors: (1) speculation that the Clinton health plan would pass and move most individuals, including Medicaid recipients, into managed care plans; (2) a perceived opportunity for profits in an inefficient environment of relatively generous Medicaid hospital payments; and, perhaps most important, (3) the state’s “rollover” policy, which moved PCP enrollees into HMOs if their PCP belonged to the network of a Medicaid HMO.

The state initiated the rollover strategy in early 1994. The Medicaid agency mailed letters to selected enrollees in the PCP program, informing them that they would be rolled over into their current PCP’s HMO unless they asked to remain in the PCP program. (Only Medicaid clients whose PCPs belonged to a...
A panel of a contracting Medicaid HMO were selected to be rolled over.) With the exception of disabled individuals, those who opted out of the HMO were informed they would have to seek another PCP. The rollovers occurred over a period of months, with one plan after another converting its primary care physicians’ patients to HMO membership.

In December 1995, nearly two years after the first rollover, a new HMO called Colorado Access was formed by several safety net hospitals and health centers in Denver and surrounding counties. (The Medicaid HMO of Denver Health and Hospitals, ChoiceCare, which began enrolling clients in 1994, was subsumed by Colorado Access. ChoiceCare officially transferred its 20,000 members to the new HMO in January 1996.) The owners of Colorado Access are Denver Health and Hospital Authority, University Hospital, Children’s Hospital, and a network of federally qualified health centers (FQHCs). At the beginning of 1996, the new HMO had 55 percent of the state’s Medicaid HMO enrollees—more than twice as many as the next leading HMO, Rocky Mountain.

The state’s rollover approach was successful in increasing the number of capitated Medicaid recipients sevenfold; only a few hundred asked to return to the PCP program. Yet the conversion process was not without controversy. Some HMOs considered unfair the large number of recipients who were enrolled in Colorado Access. The rollover policy was also criticized by groups representing disabled persons, who had concerns about service limitations of HMOs and restrictions on choice of providers. Finally, some faulted the implementation of the policy as not being forthright with Medicaid beneficiaries. As a result of the controversy and subsequent pressure from the legislature, rollovers were halted.

In 1997, the state resumed rollovers on a limited basis in order to bring more of the Medicaid population under capitation. The state has produced “friendlier” materials to inform beneficiaries of the conversion process, and it has suggested that HMOs urge physicians in their networks to initiate the conversion of patients currently in the PCP program. The state also requires that if a physician joins the network of a Medicaid HMO, all of his or her new Medicaid patients must also join that HMO or find a new PCP. The intent of this policy is to eliminate any incentives to keep one’s more expensive patients in the fee-for-service PCP program. An exception to the policy was made for the disabled, who may opt to remain in the PCP program.

**Recent Legislation**

Senate Bill 97-5, signed into law June 3, 1997, builds on the state’s current efforts, establishing the goal of 75 percent enrollment of Medicaid clients in managed care by the year 2000. The effort to expand managed care enrollment began several years ago when the state legislature, frustrated by rising Medicaid costs, passed legislation to withdraw from Medicaid. The governor vetoed that bill. The following year, new legislation established a committee of legislators, health care practitioners, and others to develop solutions to the rising costs. A
Medicaid managed care bill that mandated 100 percent enrollment of recipients was drafted, but it encountered serious opposition and did not pass in the 1995–96 session. Another interim committee, formed in the summer of 1996, produced SB 97-5.

Less ambitious than its predecessor, SB 97-5 does not require that all Medicaid recipients enroll in managed care, and it continues the PCP program to satisfy the demands of advocates for the disabled. However, the Department of Health Care Policy and Financing plans to strongly encourage enrollment in HMOs using its current methods. In addition, the state’s preference for HMOs will be manifested in the autoassignment default algorithm: clients will be given a choice, but those who do not express a preference will be assigned to an HMO.

Expanded enrollment in HMOs and, more specifically, the associated savings (estimated at 5 percent of fee-for-service expenditures) are essential to the full implementation of SB 97-5 and other legislation. A large share of the projected savings ($1.9 million) from SB 97-5 in year one will fund an enrollment broker program to assist in educating Medicaid recipients about managed care and enrolling them in a health plan. The additional resources are, in part, an attempt to shore up the enrollment process at the county level, which has been blamed for shortfalls in managed care participation. (Of those beneficiaries mandated to enroll in the PCP program, 27 percent remained in traditional fee-for-service as of FY 1996.) Some providers in the Colorado Access network are concerned that the enrollment broker may channel recipients to HMOs less suited to their needs simply to increase enrollment in private plans. Some observers expect that an enrollment broker, in addition to serving as a source for nonbiased information on health plans, may indeed level the playing field between Colorado Access and commercial plans, some of which believe that Colorado Access has received favorable treatment from the state. However, many of the new enrollees will be people currently served by providers who make up Colorado Access and, thus, will likely select or be assigned to Colorado Access.

Beginning in year two, savings from SB 97-5 will be allocated primarily to the Children’s Basic Health Plan, described earlier, with some savings also directed to grants for “essential community providers” (e.g., community health centers), which stand to lose financially from the switch to managed care. SB 97-5 includes another provision to aid essential community providers: HMOs with Medicaid contracts are required to negotiate in good faith with these providers to add them to their networks.

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**HMO Contracting Issues**

**Capitation Rates**

Until FY 1998, HMO capitation rates were set at 95 percent of the average historical per capita fee-for-service costs for each Medicaid eligibility category. 10
Within AFDC/TANF and related eligibility categories, rates were set separately for adults and children. Rates were also adjusted to account for paying FQHCs 100 percent of reasonable costs—for those HMOs with FQHCs in their network. Finally, rates were differentiated by location—the Denver metropolitan area versus the rest of the state.

As of FY 1998, Colorado’s Medicaid program employs a diagnosis-based risk-adjustment system to set capitation rates. In adopting this payment system, the state became one of the first in the country to adjust Medicaid payments to HMOs for health status of enrollees. Developed by Richard Kronick and colleagues, the risk-adjustment system is based on high-cost diagnoses as reported on HMO encounter data. The diagnoses are used to develop case-mix factors for AFDC-related children, AFDC-related adults, and disabled persons—for each HMO. Case-mix factors are multiplied by the base payment rate (derived from fee-for-service costs, adjusted for diagnoses as well) to derive capitation payments for each HMO.11 (Geographic and FQHC adjustments continue to be made.)

Although HMOs generally appear satisfied with capitation rates, Rocky Mountain HMO is an exception. In May 1997, it canceled its contract with Medicaid for four of the counties it serves on the Western Slope because of the losses it experienced under the program. The HMO lost $1.2 million in 1996 and $600,000 in 1995 serving 1,100 Medicaid recipients. Rocky Mountain explained that the cost of health care in these counties, which include ski resort towns, is very high, and Medicaid rates do not take this fact into account.12

Currently, any HMO may participate in Medicaid if it meets the requirements of the contract. By January 1999, the state plans to institute competitive bidding for contracts. HMOs fear that competitive bidding may lead to lower rates. Colorado Access, which is thriving financially at present, is concerned that competitive bidding could force it to reduce payments to safety net providers. Such cutbacks could have serious consequences for some providers in its network, especially University Hospital because of its relatively costly teaching and research functions. Moreover, Colorado Access could have problems competing successfully while maintaining its providers’ commitment to serve the uninsured.

Quality Standards

In its 1997 contract with HMOs, the state substantially increased and enhanced its quality requirements. Up to that point, HMO regulations enforced by the Department of Public Health and Environment were limited and, having been established 20 years ago, very dated. The current contract includes standards for provider network adequacy, quality assurance, and grievance procedures. The Department of Health Care Policy and Financing “will ensure compliance with these standards through annual HMO evaluations, tracking of complaints and grievances, customer satisfaction surveys, and focused studies of particular clinical and service delivery topics.”13 Health Plan Employer Data and Information Set (HEDIS) reporting will also be required.
Managed Care for the Mentally Ill and Elderly Populations

In most Colorado counties, Medicaid recipients who receive mental health services do so through a carve-out program, in which mental health services are administered and paid for separately from other health benefits. (In Denver, however, beginning June 1, 1998, mental and physical health services will be covered under a single managed care contract awarded to Colorado Access.) As of May 1997, 69 percent of the Medicaid population (51 of 63 counties) was served by the Mental Health Capitation Pilot Program. The program, begun in 1995, is run through seven contractors, or Mental Health Assessment and Service Agencies (MHASAs), which are chosen in a competitive bid process. Every Medicaid enrollee in the service area of a particular MHASA receives all mental health services through that MHASA. Most community mental health centers serve as MHASAs, a few in partnership with a for-profit managed mental health care company. Statewide expansion of the program was slated for completion in June 1998.

In FY 1995-96, the state required bids at a level no higher than 95 percent of anticipated total payments (for all beneficiaries, regardless of mental health status) under a fee-for-service system. The bids came in even lower—91.5 percent of the anticipated total, for a projected savings of $6.5 million.14 A unique feature of the program is the requirement that nonprofit MHASAs reinvest any revenues over expenses in services for non-Medicaid, indigent clients; for-profit MHASAs are held to no more than a 5 percent profit.15

Some controversy surrounds the program, particularly in the area of psychiatric hospital services. In counties where the program was instituted, inpatient expenditures fell 66 percent from FY 1994-95 to FY 1995-96.16 Although advocates have historically sought a reduction in use of institutions, they worry that this change was achieved through a decrease in the quality of care and availability of services. They also contend that proper oversight has been lacking. The state has been working to resolve these concerns and has established a performance indicator system and a high-profile grievance system.

The state’s major experiment with managed care for the elderly rests with a demonstration in Mesa County, the Integrated Long-Term Care and Financing Project. The project represents an effort to combine Medicaid and state-funded long-term care services with Medicare-funded services, resulting in coordination of both acute and long-term care services under one plan. The plan, Rocky Mountain HMO, will enroll dual eligibles on a voluntary basis. The goal is to achieve savings by eliminating the incentive to shift patients to various settings depending on who will pay for the service. The Section 1115 waiver needed to implement this program, the second such waiver granted in the nation, was approved by the federal government in August 1997.
Delivering Health Care to the Uninsured and Low-Income Populations

Colorado has a relatively strong safety net of hospitals and clinics, supported in part by the Colorado Indigent Care Program and DSH programs. The state’s public health system also meets some of the important health care needs of the uninsured. The role of public health departments in the safety net is discussed below, followed by a description of the health care delivery system for low-income residents of the Denver area.

The Role of the Public Health System

In addition to the broader public health responsibilities they hold, local health departments are an essential component of the safety net in many Colorado counties. Local health units are the delivery arm of the state’s public health system; they include 14 “organized” health departments and 39 county nursing units. County nursing units are established in rural counties that can support only a limited staff—often one public health nurse. Local health units of all sizes have commonly provided well-child care, prenatal care, and services for children with special health needs, including enhanced services such as case management. In the early 1990s, many local health departments began to bill Medicaid for these
services; consequently, Medicaid grew as a share of health department revenues. The most important revenue source appears to be local taxes, which comprised approximately half of local health unit funding in the early 1990s.\textsuperscript{17}

Colorado’s public health system, like those in many other states, is changing as Medicaid managed care expands. Some health departments have witnessed declines in their Medicaid revenues because former patients are now linked with private primary care physicians under managed care arrangements. Partly in response to these changes, the state Office of Health has promoted a return to core public health services, including prevention; yet it recognizes that in some counties, local health units remain critical providers of an array of primary care services for women and children, particularly those who are uninsured. In six counties, for example, the only provider within their boundaries is a public health nurse.

Some health departments view the changes in the Medicaid program as an opportunity to focus more on enhanced services for women and children (e.g., counseling, transportation) rather than delivery of medical services, although securing funds for such services poses a challenge. Health departments in Boulder and the Tri-County area, which borders Denver, are examples of agencies that welcome the change and have taken steps to refocus their activities. However, when the Tri-County health department attempted to scale back its delivery of prenatal and well-child services, it soon had to resume them because University Hospital closed its clinics in the health department’s jurisdiction, leaving many without a source of medical care. In rural areas where the Primary Care Physician program more commonly enrolls Medicaid beneficiaries than do HMOs, change is also evident. Public health nurses have increasingly referred patients to a PCP rather than provide the care themselves.

Because some local health departments still play a role in the provision of medical services, the Office of Health is working with them to establish relationships with HMOs. In general, local health units have had difficulty obtaining contracts with HMOs because they do not have physicians on staff or offer comprehensive primary care services. However, some HMOs are approaching local health units, and, in at least one county, an HMO is now contracting with the local health unit for home visits by nurses. (Health departments are considered “essential community providers” with whom HMOs must make good-faith efforts to contract.) The Office of Health has also worked with state Medicaid staff to encourage the inclusion of public health priorities in the HMO contract. It counts as successes the requirement for HEDIS reporting, the coverage of certain prevention services, and the designation of school-based clinics as Medicaid providers.

\section*{Impact of Government Policies and Market Changes on Safety Net Providers in Denver}

The health care market in Denver is highly competitive among both hospitals and health plans. At the beginning of the decade there were 20 indepen-
dent hospitals in the Denver metropolitan area—all private, voluntary institutions. Since then, most of these hospitals have either closed or become part of one of the three hospital systems in the area. Observers feel that more closings are likely.18

The managed care market in Denver is also very active. There are 20 HMOs currently licensed to do business in the state, and other insurers, such as Aetna, are actively seeking to develop an HMO product for Colorado. Of the 20 HMOs, 6—including Colorado Access—currently have contracts under Medicaid. Competition among Medicaid plans is relatively moderate, but legislation passed in 1997 (SB 97-5) may change this situation as it expands the number of Medicaid eligibles enrolled in managed care.

The main source of care for the medically indigent in the Denver metropolitan area is Denver Health and Hospital Authority, a publicly funded system (which operates independently of the city and county) that links Denver Health Medical Center (DHMC) and 10 FQHCs. In 1995, DHH provided approximately 50 percent of the charity care in the Denver metropolitan area. Other important safety net hospitals in the metropolitan area are University Hospital (30 percent of the area’s charity care) and Children’s Hospital (3 percent). DHMC serves the indigent of the city of Denver. University Hospital serves the indigent of the Denver suburbs and functions as the specialty referral center for the DHH clinics. Children’s Hospital provides children’s specialty services for both DHH and University Hospital. Trauma services are consolidated at DHMC.

Ambulatory care for medically indigent persons in the Denver area is provided largely by DHH clinics. These clinics also provide some of the services typically delivered by local health departments, including immunizations and screening. (Like other counties in the state, Denver’s local health department has shifted its focus toward the provision of core public health functions such as environmental health and disease control. The local health department is located on the DHH campus.) A number of nonprofit community clinics also provide care for the low-income population in the Denver area. The largest of these nonprofit clinics are Clínica Campesina, Salud Family Health Centers, and the Metropolitan Denver Provider Network.

The safety net overall is faring well in Denver as a result of six years of unprecedented growth in the economy; the state’s lower-than-average rate of uninsurance, which lessens providers’ uncompensated care burden; and the safety net’s enviable position in the Medicaid managed care market through Colorado Access. Nevertheless, the safety net’s financial stability may be somewhat tenuous. Recent changes in the local health care market and state policy decisions have significantly raised the level of concern among safety net providers. First, respondents indicated that the number of uninsured and underinsured persons in Colorado was rising as a result of changes in the local economy. While Denver’s economy is strong, many of the new jobs that have been created are in the small business sector or are part-time and do not include health insurance benefits. If economic growth slows and the
uninsured rate continues to increase, the safety net will be at risk, given the state’s limited Medicaid program.

Second, uncertainties about state Medicaid policy have contributed to unease among safety net providers. Most safety net providers believe that SB 97-5, the 1997 legislation to increase Medicaid HMO enrollment, has the potential to undermine their relatively stable position, depending on how the legislation is implemented. As more HMOs enter the capitated managed care market, issues such as the allocation of default assignments to HMOs other than Colorado Access, the level of capitated rates if competitive bidding is introduced, and competition for patients will become very important. Increased competition is likely to put a strain on the safety net generally, and specifically on the coalition of providers that created Colorado Access, as potentially divisive issues such as cost control and allocation of members among the institutions emerge.

Increasing competitive pressure has forced safety net institutions to develop a number of survival strategies. The establishment of Colorado Access is a key example of how safety net providers have made a concerted effort to position themselves in a competitive market. DHH’s integration of the primary care system with the hospital has allowed it not only to track patients but also to monitor and evaluate physician clinical practices and outcomes, so that changes can be made in physician behavior to increase efficiency.

Safety net hospitals and clinics are also developing initiatives designed to bring in additional revenues. DHH has developed special managed care products (including an HMO designed to capture the middle-income minority population, a Medicare managed care initiative, and health care for prisoners), as well as programs designed to capture particular markets, such as a substance abuse clinic for the state and sexually transmitted disease and AIDS home care programs. Moreover, one community clinic was attempting to generate more third-party billing by attracting additional commercially insured patients. Another clinic has taken the approach of marketing to families with the offer of continuity of care no matter what their current or future eligibility may be, hoping to gain their loyalty so that they will remain patients of the clinic when they are insured.
Long-Term Care
for the Elderly and
Persons with Disabilities

Background

In contrast to the attention focused on children, long-term care issues are not a major problem in Colorado, for a number of reasons. First, the state has a substantially smaller share of its population over age 65 (8.5 percent) than the United States as a whole (12.1 percent). In addition, most of the elements of its public long-term care system have been in place for some time, and state officials generally express satisfaction with the system. It is somewhat surprising that long-term care has not captured more attention, however, given that for FY 1997-98 the state was projecting a 13.8 percent increase in Medicaid long-term care costs compared with a 6.3 percent increase in acute care services.

Passage of a major payment system change for nursing home care did focus on reducing costs in 1997.

Spending

In Colorado as in other states, Medicaid is by far the largest source of public financing for long-term care for the elderly and disabled. In 1995, the state spent a total of $491 million on long-term care for these groups, or 31 percent of the entire Medicaid budget (table 6). Long-term care expenditures increased by 15.9 percent between 1990 and 1992 and by 9.1 percent between 1992 and 1995, slightly above the national average for both periods. Spending growth has been most dramatic in the area of home care. In 1990, 37 percent of long-term
<table>
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<th>Medicaid Long-Term Care Expenditures by Eligibility Group, Colorado and United States ($ in Millions)</th>
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Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.
* Includes nursing home care, intermediate care facilities for the mentally retarded, and mental health services.
care expenditures on the disabled were for home care; the figure had risen to 64 percent five years later. For the elderly, the proportion of long-term care that is home care is small, but it also rose during the 1990–1995 period, from 6 percent to 9 percent.

**Overview of Services**

Expansion of home health services in Colorado has largely come through Medicaid home and community-based services (HCBS) waivers. The state has at least six waivers in place, each targeted at a distinct category of disabled persons. HCBS waivers for developmentally disabled and mentally ill populations are administered through the Department of Human Services; the waiver for the elderly, blind, and disabled is administered by the Department of Health Care Policy and Financing. The small number of enrollees per waiver and separate administrative structures reportedly create large administrative burdens. Further, the waiver approval process was described by one state official as “long, arduous, time-consuming.”

Institutional care, particularly nursing home care, still accounts for the majority of long-term care spending in Colorado. An estimate of the number of Medicaid nursing home recipients was 10,620 in 1996, whereas the number of participants in the HCBS waiver for the elderly, blind, and disabled population was estimated to be about half this number—between 5,200 and 6,000. (Other state programs, as described below, would increase the number of persons served in the community above the number of nursing home residents.) The rate of growth in nursing home beds has been very modest. Since 1980, the number of nursing home beds has increased only 11.7 percent, compared with 33.5 percent nationally. Nursing home beds are at about the same level of availability in Colorado as for the country as a whole (55 per 1,000 elderly in Colorado compared with the United States average of 53). Occupancy rates averaged 89 percent in 1993, which was lower than the national average of 95 percent.

Significant public monies also support institutional care for those with mental illnesses or developmental disabilities. The state operates two mental hospitals, whose combined bed count has declined to less than 1,000 since the beginning of the decade. In contrast, 57,000 persons with mental illness were served in publicly supported community programs in FY 1995-96. The state also runs several facilities for persons with developmental disabilities. Facilities include Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) and group homes; they range in size from more than 100 residents to fewer than 6. There are also numerous private residential care settings, including two private ICFs/MR.

The state operates two additional long-term care programs, using only state funds. The first of these programs is the Home Care Allowance, which provides a cash grant to families, giving them the flexibility to purchase needed services to maintain a disabled family member in the home. In 1996, 5,796 per-
sons, most of whom were nonelderly, were served by this program. In addition, the state has a small Adult Foster Care program that provides 24-hour (nonmedical) supervised residential care. The program served just 537 persons in 1996.24

Finally, the Older Americans Act (OAA) provides meals and transportation to supplement the resources of many frail, elderly individuals who remain at home. The Department of Human Services annual report shows that 137,537 Coloradans received OAA services in 1996.

Long-Term Care for the Elderly

Colorado has undertaken a number of efforts to contain public spending on long-term care services for the elderly and improve the coordination and quality of care. Strategies range from managed care to reduced nursing home payment rates. The state has been somewhat less aggressive in seeking new sources of long-term care financing.

Medicare Maximization and Efforts to Attract More Private-Sector Resources

While several state officials expressed a desire to use resources other than Medicaid for funding long-term care, there seems to be little emphasis on such initiatives. For example, no conscientious effort to exploit Medicare’s resources seems to be under way. Moreover, encouraging long-term care insurance is viewed favorably but not as a likely means for saving Medicaid dollars. Some officials suggested that there may be little relationship between those who buy private insurance and Medicaid, particularly because Colorado does not have a medically needy program.

In contrast, the state has been increasingly active in estate recovery under Medicaid. In FY 1996, $2 million was recovered from estates and liens on property of current nursing home residents, up 125 percent from the 1995 level.25 New regulations were implemented in 1996 around life estates and annuities to close Medicaid loopholes allowing the transfer of assets. In addition, some resources have begun to be recovered from the income trusts that have been set up to provide a mechanism for individuals to pay a portion of their nursing home costs. The state is the beneficiary of trust monies that remain when the trust closes. In FY 1996, $648,821 was recovered.

Delivery System Changes

Colorado views its HCBS programs as highly successful, largely as a cost-saving device. A recent analysis of the state’s waiver programs concluded that they saved $53 million in 1994—an amount equal to 17 percent of the projected total Medicaid long-term care budget.26
As discussed earlier, the state is also experimenting with integrating acute and long-term care services for the dually eligible population. The Integrated Long-Term Care and Financing Project in Mesa County represents an attempt to add Medicaid and state-funded long-term care services to the package of services offered by Medicare HMOs to achieve a coordinated set of services. This program is in the early stages of operation. The state also has two Program for All-Inclusive Care for the Elderly sites.

Colorado has a single-entry-point system for qualification for all long-term care services both under Medicaid and state-only programs, sometimes referred to as Options for Long-Term Care. The system is overseen by the Aging and Adult Services unit of the Department of Human Services, which coordinates the activities of 25 geographically distributed agencies across Colorado. The single-entry system offers a comprehensive means for intake, assessment of clients, referrals, case management, resource development, and planning. The system enables the state to closely manage the care of recipients to ensure that it is appropriate and to control spending. Under the single-entry system, Medicaid recipients who pass the screens for nursing home services must pass yet another, more rigorous, screen to qualify for the HCBS waiver program. This dual screen is a conscious attempt by the state to limit the number of participants in HCBS.

Traditional Efforts to Control Expenditures

Much of the effort by Colorado to control Medicaid long-term care costs falls within the realm of traditional approaches. The lack of a medically needy program, strict standards for overall eligibility for long-term care services, and careful attention to payment levels are key components of the state’s efforts to contain costs. Since 1990, the state also has had in place a Medicaid nursing home bed moratorium. (The moratorium has not been absolute; when there are special needs, such as geographic shortages, new beds have been allowed.)

Medicaid pays nursing homes using a facility-specific prospective rate. In 1995, the per diem nursing home rate was $78, compared with a United States average of $85. Senate Bill (SB) 97-42 authorizes moving to a case-mix payment system and makes a number of other changes expected to result in savings over the current system. In addition, overall growth in payment rates will be constrained to no more than 6 percent for administrative costs and 8 percent for services each year. Officials expressed confidence in holding the line on nursing home payment levels, believing that the quality of care will not suffer. Advocates are less certain, particularly with the repeal of the Boren amendment. An April budget analysis of SB 97-42 suggested that it would save $15.7 million in FY 1998.

The state has kept payment levels for HCBS programs well below nursing home rates so that when combined with stringent eligibility requirements, program supporters assert, HCBS programs save substantial amounts of money for the Medicaid program. Reimbursement rates for home health care are on a flat-
rate fee schedule and vary from $32 for a home health aide visit to $61 for a visit by a registered nurse.

**Long-Term Care for Persons with Mental Illness and Developmental Disabilities**

A strong tradition of community-based care and local control, as well as a recent focus on managed care, define the financing and service delivery system for persons with mental and developmental disabilities in Colorado. Waiver programs have been an important part of the state’s effort to influence the delivery of the services for these populations.

**Mental Health**

The most significant undertaking in Colorado’s public mental health system in recent years is the Medicaid Mental Health Capitation pilot project. In counties where the pilot is operating, inpatient services comprised less than 20 percent of mental health spending in FY 1995-96, compared with 50 percent in the previous year. Continued downsizing of state psychiatric hospitals is expected, particularly when the capitation project is expanded statewide in 1998. Some advocates have raised concerns about the pace of change and whether the Medicaid population as well as the uninsured population are receiving adequate services. A specific concern is that mentally ill persons are being admitted inappropriately to correctional centers. To address these issues, the state has introduced measures such as greater oversight, a feature in the capititated program that directs Medicaid savings to the uninsured, and programs to reduce the large number of mentally ill persons in jails and juvenile correctional centers.

Services for Medicaid-eligible mentally ill persons are also available under an HCBS mental health waiver. Enrollment has been low; after three years in existence, the program serves only 200 persons.

**Developmental Disabilities Services**

Medicaid HCBS waivers are the cornerstone of Colorado’s strategy to deliver services to the developmentally disabled population and account for about half of public spending on developmental disability services. As of June 1996, of the 8,774 persons with developmental disabilities served in the community, two-thirds received services under a Medicaid waiver. Medicaid in total comprised 62 percent of the entire developmental disabilities budget in 1995, up from 49 percent in 1992. During the same period, state general fund support fell from 26 percent to 20 percent.
One-third of those served in the community, including many waiver participants, receive residential care. Residential care settings in Colorado are typically small. Of the developmentally disabled persons in residential settings in 1994, 73 percent were in facilities with fewer than six beds, compared with 47 percent nationally. Residential services were 45 percent of developmental disabilities expenditures in 1995.

The move to community-based care came early and was pursued aggressively in Colorado. The main waiver program is the developmentally disabled waiver, which began in 1983 and provides comprehensive residential habilitation services. This waiver is capped at approximately 3,400 persons and currently has a waiting list of 1,300 persons who are receiving no waiver services and 1,700 persons who are receiving services under another waiver but need more or different services. The legislature has not approved expansion of the program, primarily because the average per participant expenditure is $30,000 per year. The supported living services waiver is a much smaller program in terms of size (700 to 800 persons), expense per person (about $10,000), and services offered (no residential services). Many persons who are on the waiting list for the developmentally disabled waiver are currently being served through this less comprehensive waiver program. Another related home and community-based program is the Model 200 (Katie Beckett) program, which serves 400 severely disabled children from higher-income families.

The elderly, blind, and disabled waiver has only recently been open to the developmentally disabled population as a result of the June 1996 ruling in King v. Weil, which challenged the state’s waiver eligibility structure as a violation of the Americans with Disabilities Act. The lawsuit was brought because expansion of the developmentally disabled waiver did not appear forthcoming through legislative action; a commonly held assumption is that lawsuits are the only way to bring about change in the state. Another lawsuit, on which a ruling is pending, addresses the legality of waiting lists for waiver services.

The lawsuits and the fiscal reality of limited resources to address significant needs recently led to a series of recommendations from the state that stress flexibility for services through block grants to local jurisdictions, vouchers, and greater use of managed care concepts. Efforts to follow through with some of these recommendations are under way.
Continuity and Change in the State’s Health Care Policy for Low-Income Groups

Colorado’s strong dependence on employer-based health insurance and its lean Medicaid program has been a reasonable strategy in a strong economy. The number of uninsured persons is quite low, as even small employers have provided health insurance for their workers. The insurance reforms that the state has adopted over the years seem to have resulted in a stable market for such small employers. And the safety net of hospitals and clinics that care for the uninsured, particularly in Denver, has remained relatively strong.

An important challenge for the future, however, is how well the state could weather an economic downturn. High unemployment rates could push up the number of uninsured substantially, and it is not clear that Medicaid could or would fill in the gaps. Further, Colorado’s state-only programs that offer some additional protections remain very limited and might also come under great pressure during a recession in the region. This is likely the most important challenge that the state will face in the near future.

How might the state respond to slower economic growth and higher unemployment? Such a situation would mean lower state revenues. The traditional response by many states in such times is to rein in payments under Medicaid or make other adjustments to stretch resources when more people become eli-
ble for assistance. But Colorado has little fat in its Medicaid program, and hence it may be more difficult for the state to stretch its resources. Further, the revenue and spending limits that are now part of the state’s constitution would restrict any participation expansions in a short period of time.

Colorado is a high disproportionate share hospital state and hence might be able to use new means to expand its federal contributions—a technique that the state has recently rejected but might look upon more favorably during an economic downturn. Federal legislation passed in 1997 to curb states’ use of DSH payments would restrict this option somewhat, but Colorado is currently well below its DSH limit.

Colorado’s implementation of SB 97-5, which sets a goal of moving more Medicaid recipients into capitated managed care, may result in some additional challenges as well. The legislation is expected to generate savings to the Medicaid program that can be used to finance expansion of children’s health insurance. But some interviewees were skeptical of how well the state could accomplish the goals of the legislation. Moreover, if these managed care expansions move more recipients into commercial HMOs and away from Colorado Access (which helps to finance many of the safety net providers), new pressures on the safety net may emerge that will require some additional support to maintain the ability of the state’s health care system to take care of the uninsured. Similarly, public health departments are struggling somewhat in an environment of increasing Medicaid managed care, shifting in some cases from providing direct services to meeting more traditional public health functions. It is not known how well health departments can operate in this new environment or how well local and state dollars will offset any losses in Medicaid revenues.

Finally, long-term care services may also be stretched in the future. The influx of retirees into Colorado at present is likely attracting a healthier and relatively well-off subgroup of elderly. But if these retirees remain as they age, their needs for long-term care and other services may grow substantially. In that case, Colorado may face some of the same pressures as states like Florida with large elderly populations. The current long-term care system is likely inadequate to meet those needs over time.
Notes


2. Division of Mental Health Services budget documents.


17. National Association of County and City Health Officials, unpublished data.


21. American Association of Retired Persons, Across the States: Profiles of Long-Term Care Systems, 1998. (This number represents a point-in-time census, January 24, 1996.)

22. Charlene Harrington et al., 1995 State Data Book on Long-Term Care Programs and Market Characteristics, November 1996.


28. Alexis Senger, Memorandum to Joint Budget Committee Members, April 8, 1997.

30. Developmental Disabilities Services, Office of Health and Rehabilitation Services, Colorado Department of Human Services, budget documents.

APPENDIX

List of People Interviewed

Department of Health Care Policy and Financing
Vickie Akers Michelle Lasure
Richard Allen Nancy Peters
Colleen Bryan Michael Rothman
Bernie Buescher Sarah Schulte
Marilyn Golden Gary Snider
Greg Gruman Margaret Traudt

Department of Human Services
Rita Barreras Geneva Lottie
Tom Barrett Kerry Stern
Jay Kauffman

Department of Public Health and Environment
Lynn Dierker Lindy Nelson
Daniel Gossert Merril Stern
Tom Hadden

Department of Regulatory Agencies
Barbara Yondorf Division of Insurance

Office of the Governor
George Delaney Carole Poole
Carol Hedges Lisa Weil

Legislature
Senator Sally Hopper Alexis Senger

Hospitals
Frank Barrett Denver Health and Hospital Authority
Douglas Clinkscales Denver Health and Hospital Authority
Patti Gabow, M.D. Denver Health and Hospital Authority
Fred Morefield Denver Health and Hospital Authority
Stephen Berman, M.D. Children’s Hospital
Dennis Brimhall University Hospital

Community Health Centers
Jerry Brasher Salud Family Health Centers
Joanne Lindsay Salud Family Health Centers
Peter Leibig Clínica Campesina
### Health Maintenance Organizations

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<tr>
<td>Stephen O’Dell</td>
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<td>David West</td>
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### Provider Associations

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<tr>
<td>Ellen Caruso</td>
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<td>Annette Kowal</td>
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<td>Jennifer Laman</td>
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<td>Suzanne Hamilton</td>
<td>Colorado Medical Society</td>
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<td>Larry Wall</td>
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### Experts and Advocates

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<td>Phoebe Barton</td>
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<td>Buffy Boesen</td>
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<td>Steffi Clothier</td>
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<td>Virginia Fraser</td>
<td>Legal Center for People with Disabilities and Older People</td>
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<td>Michael McArdle</td>
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<td>Ralph Pollock</td>
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<td>Barbara O’Brien</td>
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<td>Mary Catherine Rabbitt</td>
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<td>Julie Reiskien</td>
<td>Colorado Cross-Disability Coalition</td>
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About the Authors

Marilyn Moon is a senior fellow with the Health Policy Center of the Urban Institute. She serves as one of the two public trustees of the Social Security and Medicare trust funds. Dr. Moon has written and spoken extensively on health policy, policy for the elderly, entitlement issues, and income distribution. In addition, she has served as the founding director of the Public Policy Institute of the American Association of Retired Persons.

Len Nichols is a principal research associate in the Urban Institute’s Health Policy Center. His recent work includes health insurance reform, Medicare reform, and medical savings accounts. Before he joined the Health Policy Center, he was senior advisor for health policy at the Office of Management and Budget and chair of the Economics Department at Wellesley College.

Stephen Norton is a research associate at the Urban Institute’s Health Policy Center, where he specializes in research on the Medicaid program, maternal and child health, and institutions providing care to the medically indigent. He is the author of a number of articles on health care.

Barbara A. Ormond is a research associate in the Urban Institute’s Health Policy Center. Her current research focuses on the effect of changes in the hospital sector on access to care by low-income populations. Her other research includes an evaluation of managed care in Medicaid. Before she joined the Urban Institute, she did research on health programs in Indonesia, Haiti, and Cameroon.

Susan Wallin is a research associate in the Urban Institute’s Health Policy Center. Previously she served as an analyst for the Physician Payment Review Commission. Her research has centered on access to care for low-income populations, including issues of health professional maldistribution, Medicaid managed care, and public health departments.
Jean Hanson served as a research associate in the Health Policy Center of the Urban Institute. She worked on a number of long-term care issues, including home health care expenditures under Medicare and Medicaid.

Laurie Pounder was a research assistant in the Urban Institute’s Health Policy Center. Her focus was on Medicare policies, specifically program financing and out-of-pocket spending by beneficiaries.
Errata

Several published *State Reports* and *Highlights* include an error in Table 1, “State Characteristics.” Incorrect figures were included for noncitizen immigrants as a percentage of the population. Corrections were made on August 13, 1998 to both the HTML and PDF version of these reports on the *Assessing New Federalism* website.

Correct figures for 1996

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**Source:** Three-year average of the Current Population Survey (CPS) (March 1996-March 1998, where 1996 is the center year) edited by the Urban Institute to correct misreporting of citizenship.

The error appears in the following publications:

State Reports:  
*Health Policy:* Alabama, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington
Income Support and Social Services: Alabama, California, Massachusetts, Michigan, Minnesota, Texas, Washington

Highlights:
Health Policy: Alabama, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Oklahoma, Texas, Washington

Income Support and Social Services: Minnesota, Texas