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Title of Rule: Revision to the Special Financing Division Colorado Indigent Care Program rules concerning HB21-1198 Implementation and CICP Alignment, Section 8.900.
Rule Number: MSB 22-03-21-A
Division / Contact / Phone: Special Financing / Taryn Graf / 5634

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 22-03-21-A, Revision to the Special Financing Division Colorado Indigent Care Program rules concerning HB21-1198 Implementation and CICP Alignment, Section 8.900.

3. This action is an adoption of: an amendmentand new rules

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.900, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: Apr 1, 2022
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.900 with the proposed text beginning at 8.900 through the end of 8.929. This rule is effective June 30, 2022.

*to be completed by MSB Board Coordinator

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STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   During the 2021 session, the Colorado General Assembly passed House Bill (HB) 21-1198 which moved the Health Care Billing Requirements for indigent patients from the Department of Public Health and Environment to the Department of Health Care Policy and Financing for creation and implementation. HB 21-1198, also known as Hospital Discounted Care, allows uninsured individuals the opportunity to apply for financial assistance or charity care programs through the Health Care Facility where they receive treatment. Health Care services covered include any services received in a general acute care or critical access hospital or free-standing emergency department.

   HB21-1198 requires designated providers to establish a monthly payment plan for indigent patients under which payments for health care facility charges may not exceed 4% of the patient's monthly household income, and payments for each licensed health care professional charges may not exceed 2% of the patient's monthly household income. After 36 cumulative payments, the patient's bill is considered paid in full. The Department determines the rates used by all health care providers which cannot be less than 100% of the Medicare rate or 100% of the Medicaid base rage, whichever is greater. This rulemaking process will simultaneously create rules for Hospital Discounted Care and update the Colorado Indigent Care Program (CICP) rules in order to minimize administrative burden for participating CICP hospital providers. Hospital Discounted Care must be implemented by April 1, 2022 per HB21-1198.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

Initial Review Final Adoption
Proposed Effective Date Emergency Adoption

DOCUMENT #

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Sections 25.5-3-501 through 25.5-3-506, C.R.S. (2021); Sections 25.5-3-101 through 25.5-3-112

Initial Review Final Adoption
Proposed Effective Date Emergency Adoption

DOCUMENT #

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REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   This rule will impact low-income households that are at or below 250% of the federal poverty level as well as all general acute and critical access hospitals, all free-standing emergency departments, and all licensed health care professionals who work within those settings. Low-income households will benefit from this rule because it requires all affected health care service providers to assess income uniformly and sets limits on payment plan amounts.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   The rule change is intended to help low-income households access health care services under an affordable payment plan to prevent bankruptcy filings due to medical costs. The impact on the health care service providers may be an increased workload to ensure all eligible patients are screened for discounted care.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   The General Assembly has appropriated funds to the Department for implementation of HB 21-1198. It is unknown whether the transfer of responsibility under HB21-1198 from the Department of Public Health and Environment will result in any cost-avoidance for that agency. The Department anticipates no other effect on state revenues.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The cost of the proposed rule is limited to the costs of implementation of HB21-1198 related to rule-making. The benefit of the proposed rule is that by setting uniform income assessment and billing standards, indigent patients are expected to be less likely to file bankruptcy because of insurmountable medical debt. The cost of inaction is that the Department would be out of compliance with the requirements of HB21-1198 and resulting statutes, and there would be no real benefit to inaction.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

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The Department does not foresee any fiscal impact from this rule change, and no less costly methods exist when the legislature has mandated rulemaking.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   No alternative methods were considered because legislation directs the Medical Services Board to establish rules for the implementation of HB 21-1198.

8.900 COLORADO INDIGENT CARE PROGRAM (CICP)

PROGRAM OVERVIEW AND LEGAL BASIS

The Colorado Indigent Care Program (CICP) is a program that distributes federal and State funds to partially compensate Qualified Health Care Providers for uncompensated costs associated with services rendered to uninsured or underinsured patients. Qualified Health Care Providers who receive this funding render discounted health care services to Colorado residents, migrant workers and lawfully present immigrants with limited financial resources who are uninsured or underinsured and not eligible for benefits under the Medicaid Program or the Children's Basic Health Plan.

The Colorado Department of Health Care Policy and Financing (Department) administers the CICP by distributing funding to Qualified Health Care Providers who serve eligible persons. The CICP issues procedures to ensure the funding is used to serve the uninsured and underinsured population in a uniform method. Any significant departure from these procedures will result in termination of the approval of, and the funding to, a health care provider. The CICP is authorized by state law at Title 25.5, Article 3, Part 1~~, (2020)~~.

The CICP does not offer a specified discounted medical benefit package or an entitlement to medical benefits or funding to individuals or medical providers. The CICP does not offer a health coverage plan as defined in section 10-16-102~~-~~(34), C.R.S. Eligible persons receiving discounted health care services from Qualified Health Care Providers are subject to the limitations and requirements imposed by Title 25.5, Article 3, Part 1, C.R.S.

8.901 DEFINITIONS

A. Applicant means an individual who has applied at a Qualified Health Care Provider to receive discounted health care services.

B. Children's Basic Health Plan or the Child Health Plan Plus (CHP+) means the Children's Basic Health Plan as defined in Title 25.5, Article 8, C.R.S.~~ (2020).~~

C. Client means an individual whose application to receive discounted health care services has been approved by a Qualified Health Care Provider.

D. Clinic Provider means any Qualified Health Care Provider that is a community health clinic licensed or certified by the Department of Public Health and Environment pursuant to C.R.S §25-1.5-103, a federally qualified health center as defined in 42 U.S.C. sec. 1395x (aa)(4)~~ (2020)~~, or a rural health clinic, as defined in 42 U.S.C. sec. 1395x (aa)(2)~~ (2020)~~.

E. Colorado Indigent Care Program or CICP or Program means the Colorado Indigent Care Program as authorized by state law at Title 25.5, Article 3, Part 1, C.R.S.~~ (2020).~~

F. Denver Metropolitan Area means the Denver-Aurora-Lakewood, CO metropolitan area as defined by the Bureau of Labor Statistics.

G. Department means the Department of Health Care Policy and Financing established pursuant to ~~Title~~section 25.5-1-104, C.R.S.~~ (2020).~~

H. Doubled-up means a person who has no permanent housing of their own and who is temporarily living with a person who has no legal obligation to financially support them.

I. Emergency Care means treatment for conditions of an acute, severe nature which are life, limb, or disability threats requiring immediate attention, where any delay in treatment would, in the judgment of the responsible physician, threaten life or loss of function of a patient or viable fetus.

J. General Provider means a general hospital, birth center, or community health clinic licensed or certified by the Department of Public Health and Environment pursuant to Section 25-1.5-103(1)(a)(I) or (1)(a)(II), C.R.S., a federally qualified health center, as defined in 42 U.S.C. sec. 1395x-(aa)(4)~~ (2020)~~, a rural health clinic, as defined in 42 U.S.C. sec. 1395x-(aa)(2)~~(2020)~~, a health maintenance organization issued a certificate authority pursuant to Section 10-16-402, C.R.S., and the University of Colorado Health Sciences Center when acting pursuant to Section 25.5-3-108-(5)(a)(I) or (5)(a)(II)(A), C.R.S. For the purposes of the Program, General Provider includes associated physicians.

42 U.S.C. sec. 1395x-(aa)(2) (~~2020~~2021)is incorporated by reference. Such incorporation, however, excludes later amendments to or editions of the referenced material. Pursuant to Section 24-4-103-(12.5), C.R.S., the Department of Health Care Policy and Financing maintains either electronic or written copies of the incorporated texts for public inspection. Copies may be obtained at a reasonable cost or examined during regular business hours at 1570 Grant Street, Denver, Colorado 80203.

K. Homeless means a person who lacks a fixed, regular, and adequate night-time residence, or is in a doubled-up situation, or is in imminent danger of losing their primary night-time residence, and who lacks resources or support networks to remain in housing, or has a primary night-time residency that is: (A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations, (B) an institution that provides a temporary residence for individuals intended to be institutionalized, or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings. This does not include an individual imprisoned or otherwise detained pursuant to federal or state law.

L. Hospital Discounted Care means Health Care Billing for Indigent Patients as defined in Title 25.5, Article 3, Part 5, C.R.S.

M. Hospital Provider means any Qualified Health Care Provider that is a general hospital licensed or certified by the Department of Public Health and Environment pursuant to section 25-1.5-103, C.R.S. and which operates inpatient facilities.

~~M~~N. Liquid Resources means resources that can be readily converted to cash, including but not limited to checking and savings accounts, health savings accounts, prepaid bank cards, certificates of deposit less the penalty for early withdrawal.

~~N~~O. Medicaid means the Colorado medical assistance program as defined in Title 25.5, Article 4, C.R.S.

~~O~~P. Qualified Health Care Provider means any General Provider who is approved by the Department to provide, and receive funding for, discounted health care services under the CICP.

~~P~~Q. Spend Down means when an Applicant uses his or her available Liquid Resources to pay off part or all of a medical bill to lower his or her financial determination to a level that will allow him or her to qualify for the Program.

~~Q~~R. Transitional housing means housing designed to provide homeless individuals and families with the interim stability and support to successfully move to and maintain permanent housing.

~~R~~S. Uniform Application means the application for discounted care created pursuant to Section 8.922.

T. Urgent Care means treatment needed because of an injury or serious illness that requires treatment within 48 hours.

8.902 PROVISIONS APPLICABLE TO QUALIFIED HEALTH CARE PROVIDERS

A. Requirements for Qualified Health Care Providers

1. Agreements will be made annually between the Department and Qualified Health Care Providers through an application process.

2. Agreements may be executed with Hospital Providers throughout Colorado that meet the following requirements:

a. Licensed or certified as a general hospital or birth center by the Department of Public Health and Environment.

b. Hospital Providers shall provide Emergency Care to all Clients throughout the Program year at discounted rates.

c. Hospital Providers shall have at least two obstetricians with staff privileges at the Hospital Provider who agree to provide obstetric services to individuals under Medicaid. In the case where a Hospital Provider is located in a rural area (that is, an area outside of a metropolitan statistical area, as defined by the Executive Office of Management and Budget), the term “obstetrician” includes any physician with staff privileges at the Hospital Provider to perform non-emergency obstetric procedures.

This requirement does not apply to a Hospital Provider in which the inpatients are predominantly under 18 years of age or which does not offer non-emergency obstetric services as of December 21, 1987.

d. Using the information submitted by an Applicant and the Uniform Application developed and distributed by the Department, the Qualified Health Care Provider shall determine whether the Applicant meets all requirements to receive discounted health care services under the Program. Eligibility shall be determined at the time of application, unless required documentation is not available, in which case the Applicant will be notified of the missing documentation within three business days. An eligibility determination shall be made within three business days of receipt of the missing documents. Hospital Providers shall determine Client financial eligibility using the following information:

I. Income from each Applicant age 18 and older;

II. Household size, where all non-spouse or civil union partner, non-student adults ages 18 to 64 included on the application must have financial support demonstrated or attested to

i. An applicant must include their spouse or civil union partner in their household for purposes of the application.

ii. Any additional person living at the same address as the applicant may also be included in the household.

iii. An applicant may include household members who live in other states or countries if the applicant attests that they provide at least 50% of the household member's support; and

III. Liquid Resources. Including Liquid Resources in the financial eligibility determination is optional for Hospital Providers. If a Hospital Provider chooses to include Liquid Resources in the financial eligibility determination, at least $2,500 must be excluded for each family member counted in household size, and the Hospital Provider must include a Spend Down opportunity. Effective ~~July~~June 1, Liquid Resources may no longer be counted for applicants.

e. Hospital Providers shall use the Sliding Fee Scale developed by the Department or submit for Department approval with their annual application a Sliding Fee Scale that shows copayments for different service categories divided into at least three income tiers covering 0 to 250% of the federal poverty level. Copayments shall be expressed in dollar amounts and shall not exceed the copayments in the Standard Client Copayment Table found in Appendix A. Hospital Providers shall inform Applicants and Clients of their copayment responsibilities at the time their application is approved.

f. Hospital Providers shall submit Program utilization and charge data in a format and timeline determined by the Department.

3. Agreements may be executed with Clinic Providers throughout Colorado that meet the following minimum criteria:

a. Licensed or certified as a community health clinic by the Department of Public Health and Environment or certified by the U.S. Department of Health and Human Services as a federally qualified health center or rural health clinic.

b. Using the information submitted by an Applicant, the provider shall use the Uniform Application developed and distributed by the Department to determine whether the Applicant meets all requirements to receive discounted health care services under the Program. Clinic Providers may develop their own application and submit it to the Department for approval. Eligibility shall be determined at the time of application, unless required documentation is not available, in which case the Applicant will be notified of the missing documentation within three business days. An eligibility determination shall be made within three business days of receipt of the missing documents. Clinic Providers who are federally qualified health centers shall determine Client financial eligibility as required under federal regulations and guidelines. Clinic Providers who are not federally qualified health centers shall determine Client financial eligibility using the following information:

I. Income from each Applicant age 18 and older, and

II. Household size.

c. Clinic Providers shall submit a Sliding Fee Scale for Department approval with their annual application that shows copayments for different service categories. Copayments for Clients between 0 and 100% of the federal poverty level shall be nominal or $0. Sliding Fee Scales shall have at least three tiers between 101 and 250% of the federal poverty level.

I. Sliding fee scales used by federally qualified health centers approved by the federal government meet all requirements of the Program.

II. Copayments for Clients between 101 and 250% of the federal poverty level may not be less than the copayments for Clients between 0 and 100% of the federal poverty level.

III. The same sliding fee scale shall be used for all Clients eligible for the Program.

IV. Sliding fee scales shall be reviewed by the Qualified Health Care Provider on a regular basis to ensure there are no barriers to care.

d. Clinic Providers shall inform Applicants and Clients of their copayment responsibilities at the time their application is approved.

e. Clinic Providers shall submit Program data and quality metrics with their annual application. Specific quality metrics are listed in Section 8.905.B. The data and quality metrics shall be submitted in a format determined by the Department and provided as part of the annual application.

4. Determination of Lawful Presence

a. Effective July 1, 2022, Applicants are no longer required to provide proof of lawful presence in order to be eligible for the CICP.

b. Qualified Health Care Providers shall develop procedures for handling original lawful presence documents to ensure that the documents are not lost, damaged or destroyed. Qualified Health Care Providers shall develop and follow procedures for returning or mailing original documents to Applicants within five business days of receipt.

~~b~~c. Qualified Health Care Providers shall accept copies of an Applicant's lawful presence documentation that have been verified by other CICP providers, Medical Assistance sites, county departments of social services, or any other entity designated by the Department of Health Care Policy and Financing through an agency letter.

~~c~~d. Qualified Health Care Providers shall retain photocopies of the Applicant's affidavit and lawful presence documentation.

~~d~~e. Qualified Health Care Providers shall assist applicants who have a disability, are homeless, or who lack proficiency in English with obtaining documentation to establish citizenship or lawful presence.

I. Examples of reasonable assistance that may be expected include, but are not limited to, providing contact information for the appropriate agencies that issue required documents; explaining the documentation requirements and how the Applicant may provide the required documentation; or referring the Applicant to other agencies or organizations which may be able to provide assistance.

II. Examples of additional assistance that shall be provided to Applicants who are unable to comply with the documentation requirements due to physical or mental impairments or homelessness and who do not have a

guardian or representative who can provide assistance include, but are not limited to, contacting any known family members who may have the required documentation; contacting any known health care providers who may have the required documentation; or contacting other social services agencies or organizations that are known to have provided assistance to the Applicant.

III. The Qualified Health Care Provider shall not be required to pay for the cost of obtaining required documentation.

IV. The Qualified Health Care Provider shall document its efforts of providing additional assistance to the Applicant and retain such documentation.

5. Qualified Health Care Providers shall provide the Applicant and/or representative a written notice of the provider's determination as to the Applicant's eligibility to receive discounted services under the Program. If eligibility to receive discounted health care services is granted by the Qualified Health Care Provider, the notice shall include the dates of eligibility and the Applicant's copay responsibilities. If eligibility to receive discounted health care services is denied, the notice shall include a brief, plain language explanation of the reason(s) for the denial. Every notice of the Qualified Health Care Provider's decision, whether an approval or a denial, shall include an explanation of the Applicant's appeal rights found at Section 8.902.B in these regulations.

6. Qualified Health Care Providers shall screen all Applicants for eligibility for Medicaid and the Children's Basic Health Plan and refer Applicants to those programs if they appear eligible. The Qualified Health Care Provider shall refer Applicants to Colorado's health insurance marketplace for information about private health insurance.

7. Qualified Health Care Providers shall not discriminate against Applicants or Clients based on race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, or disability.

B. Client Appeals

1. If an Applicant or Client feels that a financial determination or denial is in error, he or she shall only challenge the financial determination or denial by filing an appeal with the Qualified Health Care Provider who determined eligibility to receive discounted health care services under the CICP pursuant to this Section 8.902. There is no appeal process available through the Office of Administrative Courts.

2. Instructions for Filing an Appeal

The Qualified Health Care Provider shall inform the Applicant or Client that he or she has the right to appeal the financial determination or denial if he or she is not satisfied with the Qualified Health Care Provider's decision.

An Applicant or Client who wishes to appeal a denial must:

a. Submit a letter requesting appeal within ~~15 business~~30 calendar days of the date of the denial notice. Appeals submitted after the deadline may be denied for being submitted untimely;

b. Enclose any supporting documentation;

If no denial notice is received earlier, an appeal letter may be submitted within ~~30~~45 ~~business~~ calendar days of the date the application was completed.~~;~~

The deadline for an appeal letter may be extended for good cause.

3. Appeals

a. An Applicant or Client may file an appeal if he or she wishes to challenge the accuracy of his or her initial financial determination.

b. Each Qualified Health Care Provider must designate a manager to review appeals and supporting documentation.

c. If the initial financial determination is found to be inaccurate,

I. the financial determination will be corrected, with eligibility effective retroactive to the initial date of application, and

II. services provided during the applicable backdating period must be discounted.

d. A decision shall be issued to the Applicant or Client and the Department in writing within 15 ~~business~~ calendar days following receipt of the appeal request.

4. Provider Management Exception

a. An Applicant or Client may request a provider management exception simultaneously with an appeal, or within 15 ~~business~~ calendar days of the date of the Qualified Health Care Provider's decision regarding an appeal.

b. A provider management exception may be granted at the Qualified Health Care Provider's discretion if the Applicant or Client can demonstrate that there are circumstances that should be taken into consideration when establishing the household financial status.

c. Each Qualified Health Care Provider must designate a manager to review provider management exceptions and supporting documents.

I. The facility shall notify the Client in writing of the Qualified Health Care Provider's findings within 15 ~~business~~ calendar days of receipt of the Client's written request.

II. The Qualified Health Care Provider must note provider management exceptions on the application.

d. A financial determination from a provider management exception is effective as of the initial date of application.

e. Qualified Health Care Providers are not required to honor provider management exceptions granted by other Qualified Health Care Providers.

C. Financial Eligibility

General Rule: An Applicant shall be financially eligible for discounted health care services under the CICP if ~~his or her~~their household income is no more than 250% of the current Federal Poverty Guidelines~~federal poverty level~~ (FPG~~L~~)for a household of that size.

1. Qualified Health Care Providers determine eligibility for the CICP and shall maintain auditable files of applications for discounted health care services under the CICP until June 30 of the seventh state fiscal year following the eligibility determination.

2. The determination of financial eligibility process looks at the financial circumstances of a household as of the date that an application is started. In the event that an applicant is applying to cover a past individual visit or admission, or a string of visits, admissions, or both that occurred in a short amount of time~~,~~ and is either not going to be applying for CICP going forward or the date(s) of service are outside of the standard 90 day backdating window, the household financial status is considered as of the date of service instead of the date of the application.

3. All Qualified Health Care Providers must accept each other's CICP financial determinations unless the Qualified Health Care Provider believes that the financial determination was determined incorrectly, the Qualified Health Care Provider's financial determination process is materially different from the process used by the issuing Qualified Health Care Provider, or that the financial determination was a result of a provider management exception.

4. CICP eligibility is retroactive for services received from a Qualified Health Care Provider up to 90 days prior to application.

5. Documentation concerning the Applicant's financial status shall be maintained by the provider until June 30 of the seventh state fiscal year following the eligibility determination.

6. Beyond the distribution of available funds made by the CICP, allowable Client copayments, and other third-party sources, a provider shall not seek payment from a Client for the provider's CICP discounted health care services to the Client.

7. Emergency Application for Providers

   a. In emergency circumstances, an Applicant may be unable to provide all of the information or documentation required by the usual application process. For emergency situations, the Qualified Health Care Provider shall follow these steps in processing the application:

      I. Use the regular application to receive discounted health care services under the CICP but indicate emergency application on the application.

      II. Ask the Applicant to give spoken answers to all questions and determine a federal poverty level based on the spoken information provided. If the Applicant appears eligible for Medicaid or CHP+, the Applicant will need to apply for the applicable program prior to being placed on CICP.

      III. .Ask the Applicant to sign the application indicating their understanding of their federal poverty level and eligibility determination made using their spoken information.

   b. An emergency application is good for only one episode of service in an emergency room and any subsequent service related to the emergency room

episode. If the Client receives any care other than the emergency room visit, the Hospital Provider must request the Client to submit documentation to support all figures on the emergency application or complete a new application. If the documentation submitted by the Client does not support the earlier, spoken information, the Hospital Provider must obtain a new application from the Client. If the Client does not submit any supporting documentation or complete a new application upon the request of the provider, the provider shall use the information contained in the emergency application.

c. In emergency circumstances, an Applicant is not required to provide identification or execute an affidavit as specified at Section 8.904.D.

D. Audit Requirements

The Department will conduct audits of Qualified Health Care Providers. Qualified Health Care Providers shall comply with requests for data and other information from the Department. Qualified Health Care Providers shall complete corrective actions when required by the Department. The Department's intention is to audit one-third of the participating Qualified Health Care Providers each year. After any Qualified Health Care Provider discontinues participation in the program, the provider must maintain compliance with audit requirements for the records created during the period during which the Qualified Health Care Provider was participating.

E. HIPAA

The CICP does not meet the definition of a covered entity or business associate under the Health Insurance Portability and Accountability Act of 1996 at 45 C.F.R. sec. 160.103. The CICP is not a part of the Colorado Medical Assistance Program, nor of Health First Colorado, Colorado's Medicaid program. CICP's principal activity is the making of grants to providers who serve eligible persons who are uninsured or underinsured. The state personnel administering the CICP will provide oversight in the form of procedures and conditions to ensure funds provided are being used to serve the target population, but they will not be significantly involved in any health care decisions or disputes involving a Qualified Health Care Provider or Client.

8.903 DISCOUNTED HEALTH CARE SERVICES

A. Funding provided under the CICP shall be used to provide Clients with discounted health care services determined to be medically necessary by the Qualified Health Care Provider.

B. All health care services normally provided at the Qualified Health Care Provider should be available at a discount to Clients. If health care services normally provided at the Qualified Health Care Provider are not available to Clients at a discount, Clients must be informed that the services can be offered without a discount prior to the rendering of such services. Service availability is to be applied uniformly for all Clients.

C. Qualified Health Care Providers receiving funding under the CICP shall prioritize the use of funding such that discounted health care services are available in the following order:

1. Emergency Care;

2. Urgent Care; and

3. Any other medical care.

D. Additional discounted health care services may include:

1. Emergency mental health services if the Qualified Health Care Provider renders these services to a Client at the same time that the Client receives other medically necessary services.

2. Qualified Health Care Providers may provide discounted pharmaceutical services. The Qualified Health Care Provider should only provide discounted prescriptions that are written by doctors on its staff, or by a doctor that is under contract with the Qualified Health Care Provider. Qualified Health Care Providers shall exclude prescription drugs included in the definition of Medicare Part-D from eligible Clients who are also eligible for Medicare.

3. Qualified Health Care Providers may provide packages of services to patients with modified copayment requirements.

    a. Packages of services benefit Clients who need to utilize services more often than average Clients. Things that would be beneficial to the client include but are not limited to charging a lower copay, charging the copay on an alternative schedule (i.e. once a week, or ever other time), or setting a cap on the amount or number of copayments made towards the packaged services. Examples of packages may include but are not limited to oncology treatments, physical therapy, and dialysis.

    b. Qualified Health Care Providers may provide a prenatal benefit with a predetermined copayment designed to encourage access to prenatal care for uninsured or underinsured women. This prenatal benefit shall not cover the delivery or the hospital stay, or visits that are not related to the pregnancy. The Qualified Health Care Provider is responsible for providing a description of the services included in the prenatal benefit to the Client prior to services rendered. Services and copayments may vary among sites.

E. Excluded Discounted Health Care Services

Funding provided under the CICP shall not be used for providing discounted health care services for the following:

1. Non-urgent dental services.

2. Nursing home care.

3. Chiropractic services.

4. Cosmetic surgery.

5. Experimental and non-United States Federal Drug Administration approved treatments.

6. Elective surgeries that are not medically necessary.

7. Court ordered procedures, such as drug testing.

8. Abortions - Except as specified in ~~S~~section 25.5-3-106, C.R.S.

9. Mental health services in clinic settings pursuant to section 25.5-3-110, C.R.S., Title 27, Article 66, Part 1, any provisions of Title 23, Article 22, C.R.S., or any other provisions of law relating to the University of Colorado Psychiatric Hospital.

8.904 PROVISIONS APPLICABLE TO CLIENTS

A. Overview of Requirements

In order to qualify to receive discounted health care services under available CICP funds, an Applicant shall satisfy the following requirements:

1. Execute an affidavit regarding citizenship status;

   a. Beginning on July 1, 2022, applicants are no longer required to execute an affidavit regarding citizenship status.

2. Be lawfully present in the United States;

   a. Beginning on July 1, 2022, applicants are no longer required to be lawfully present in the United States.

3. Be a resident of Colorado;

4. Meet all CICP eligibility requirements as defined by state law and procedures; and

5. Furnish a social security number (SSN) or evidence that an application for a SSN has been submitted, or meet one of the following exceptions:

   a. individual is an unborn child;

   b. individual is homeless and unable to provide a SSN;

   c. individual is ineligible for a SSN:

   d. individual may only be issued a SSN for a valid non-work reason in accordance with 20 C.F.R. sec. 422.104;

   e. individual refuses to obtain a SSN because of well-established religious objections.

B. Applicants

1. Any adult age 18 and older may apply to receive discounted health care services on behalf of themselves and members of the Applicant's family household.

2. If an Applicant is deceased, the ~~executor~~ personal representative of the estate or a family member may complete the application on behalf of the Applicant. The family member completing the application will not be responsible for any copayments incurred on behalf of the deceased member.

3. The application to receive discounted health care services under available CICP funding shall include the names of all members of the Applicant's family household. All non-spouse or civil union partner, non-student adults ages 18-64 must have financial support demonstrated or attested to in order to be included in household size. All minors and those 65 or older do not need documentation of financial support to be counted in household size. Income from spouses or civil union partners and all non-student adults must be included in the application.

4. A minor shall not be rated separately from his or her parents or guardians unless he or she is emancipated or there exists a special circumstance. A minor is an individual under the age of 18.

C. Signing the Application

The Applicant or an authorized representative of the Applicant must sign the application to receive discounted health care services submitted to the Qualified Health Care Provider within 90 calendar days of the date of health care services. If an Applicant is unable to sign the application or has died, a spouse, civil union partner, relative, or guardian may sign the application. Until it is signed, the application is not complete, the Applicant cannot receive discounted health care services under the CICP, and the Applicant has no appeal rights. All information needed by the provider to process the application must be submitted before the application is signed.

D. Affidavit

1. Each first-time Applicant, or Applicant seeking to reapply, 18 years of age or older shall execute an affidavit stating:

   a. That he or she is a United States citizen, or

   b. That he or she is a legal permanent resident or is otherwise lawfully present in the United States pursuant to 1 CCR 204-30; Rule 5.

2. For an Applicant who has executed an affidavit stating that he or she is lawfully present in the United States but is not a United States citizen, the provider shall verify lawful presence through the Federal Systematic Alien Verification for Entitlements (SAVE) Program operated by the United States Department of Homeland Security or a successor program designated by the United States Department of Homeland Security within three business days of receipt of the lawful presence documentation. A SAVE verification is not needed for Applicants who provide an ID issued by a REAL ID Act compliant state that bears the REAL ID Act indicator.

3. Effective July 1, 2022, Applicants are no longer required to execute an affidavit of lawful presence.

E. Establishing Lawful Presence

1. Each first-time Applicant, or Applicant seeking to reapply, eighteen years of age or older shall be considered lawfully present in the country if they produce a document or waiver in accordance with 1 CCR 204-30; Rule 5 (effective September 17, 2020), which is hereby incorporated by reference. This incorporation of 1 CCR 204-30; Rule 5 excludes later amendments to, or editions of, the referenced material. Pursuant to Section 24-4-103-(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.

2. Submission of Documentation

   Lawful presence documentation may be accepted from the Applicant, the Applicant's spouse, civil union partner, parent, guardian, or authorized representative in person, by mail, by email, or facsimile.

3. Expired or absent documentation for non-U.S. citizens

a. If an Applicant is unable to present any documentation evidencing his or her immigration status, refer the Applicant to the local Department of Homeland Security office to obtain documentation of status.

b. In unusual circumstances involving Applicants who are hospitalized or medically disabled or who can otherwise show good cause for their inability to present documentation and for whom securing such documentation would constitute undue hardship, if the Applicant can provide an alien registration number, the provider may file U.S.C.I.S. Form G-845 and Supplement, along with the alien registration and a copy of any expired Department of Homeland Security document, with the local Department of Homeland Security office to verify status.

c. If an Applicant does not present documentation proving their lawful presence but instead presents a receipt indicating that he or she has applied to the Department of Homeland Security for a replacement document, file U.S.C.I.S. Form G-845 and Supplement with a copy of the receipt with the local Department of Homeland Security office to verify status.

4. Effective July 1, 2022, Applicants are no longer required to provide proof of lawful presence.

F. Residence in Colorado

An Applicant must be a resident of Colorado. A Colorado resident is a person who currently lives in Colorado and intends to remain in the state.

Migrant workers and all dependent family members must meet all of the following criteria to comply with residency requirements:

1. Maintains a temporary home in Colorado for employment reasons;

2. Meet the lawful presence criteria, as defined in paragraph E of this Section; and

3. Employed in Colorado.

G. Applicants Not Eligible

1. The following individuals are not eligible to receive discounted services under the CICP:

a. Individuals for whom lawful presence cannot be verified.

I. Effective July 1, 2022, lawful presence is no longer a requirement for CICP, and these individuals are no longer ineligible for discounted services.

b. Individuals who are being held or confined involuntarily under governmental control in State or federal prisons, jails, detention facilities or other penal facilities. This includes those individuals residing in detention centers awaiting trial, at a wilderness camp, residing in half-way houses who do not have freedom of movement and association, and those persons in the custody of a law enforcement agency temporarily released for the sole purpose of receiving health care.

c. College students whose residence is from outside Colorado or the United States that are in Colorado for the purpose of higher education. These students are not Colorado residents and cannot receive services under the CICP.

d. Visitors from other states or countries temporarily visiting Colorado and have primary residences outside of Colorado.

e. Persons who qualify for Medicaid. However, Applicants whose only Medicaid benefits are the following shall not be excluded from consideration for CICP eligibility:

I. QMB benefits described at Section 8.100.6.L ~~(2016)~~ of these regulations;

II. SLMB benefits described at Section 8.1006.M ~~(2016)~~, or

III. The QI1 benefits described at Section 8.100.6.N ~~(2016)~~.

f. Individuals who are eligible for the Children's Basic Health Plan.

H. Health Insurance Information

The Applicant shall submit all necessary information related to health insurance, including a copy of the insurance policy or insurance card, the address where the medical claim forms must be submitted, policy number, and any other information determined necessary.

I. Subsequent Insurance Payments

If a Client receives discounted health care services under the CICP, and their insurance subsequently pays for services, or if the Client is awarded a settlement, the insurance company or patient shall reimburse the Qualified Health Care Provider for discounted health care services rendered to the Client.

8.905 DEPARTMENT RESPONSIBILITIES

A. Provider Application

1. The Department shall produce and publish a provider application annually.

a. The application will be updated annually to incorporate any necessary changes and update any Program information.

b. The application will include data and quality metric submission templates.

2. The Department shall determine Qualified Health Care Providers annually through the application process.

3. An agreement will be executed between the Department and Denver Health for the purpose of providing discounted health care services to the residents of the City and County of Denver, as required by Section 25.5-3-108 (5)(a)(I), C.R.S.

4. An agreement will be executed between the Department and University Hospital for the purpose of providing discounted health care services in the Denver Metropolitan Area and complex care that is not contracted for in the remaining areas of the state, as required by Section 25.5-3-108 (5)(a)(II), C.R.S.

5. The Department shall produce and publish a provider directory annually.

B. Payments to Providers

1. Funding for hospitals shall be distributed in accordance with Sections 8.300 and 8.905.B.3.

2. Clinics

a. Funding for Clinic Providers is appropriated through the Colorado General Assembly under the Children's Hospital, Clinic Based Indigent Care line item. Effective July 1, 2018, funding for clinics shall be separated into two different groups, as follows:

I. 75 percent of the funding will be distributed based on Clinic Providers' write off costs relative to the total write off costs for all Clinic Providers.

II. 25 percent of the funding will be distributed based on a points system granted to Clinic Providers based on their quality metric scores multiplied by the Clinic Provider's total visits from their submitted Program data.

b. The quality metric scores will be calculated based on the following four metrics. The metrics are defined by the Health Resources & Services Administration (HRSA):

I. Preventative Care and Screening: Body Mass Index (BMI) Screening and Follow Up

II. Preventative Care and Screening: Screening for Clinical Depression and Follow-up Plan

III. Diabetes: Hemoglobin A1c Poor Control

IV. Controlling High Blood Pressure

c. Write off costs will be calculated as follows:

I. Distribution of available funds for CICP care costs will be calculated based upon historical data. Third-party liabilities and the patient liabilities will be deducted from total charges to generate CICP charges.

II. Clinic Providers shall deduct amounts due from third-party payment sources from total charges declared on the summary statistics submitted to the Department.

III. Clinic Providers shall deduct the full patient liability amount from total charges, which is the amount due from the Client as identified in the CICP Standard Client Copayment Table, as defined under Appendix A in these rules, or an alternative sliding fee scale that is submitted by the provider with the annual application for the CICP and approved by the Department. The summary information submitted to the Department by the provider shall include the full CICP patient liability amount even if the Clinic Provider receives the full payment at a later date or through several smaller installments or no payment from the Client.

IV. CICP charges will be converted to CICP costs using the most recently available cost-to-charge ratio from the Clinic Provider's cost report or other financial documentation accepted by the Department.

d. The Department shall notify Clinic Providers of their expected payment no later than August 31 of each year. The notification shall include the total expected payment and a description of the methodology used to calculate the payment.

3. Pediatric Major Teaching Hospital Payment. Hospital Providers shall qualify for additional payment when they meet the criteria for being a major teaching hospital provider and when their Medicaid-eligible inpatient days combined with CICP care days (days of care provided under the CICP) equal or exceed 30 percent of their total inpatient days for the most recent year for which data are available. A major teaching hospital provider is defined as a Colorado hospital, which meets the following criteria:

a. Maintains a minimum of 110 total Intern and Resident (I/R) F.T.E.s;

b. Maintains a minimum ratio of .30 Intern and Resident (I/R) F.T.E.s per licensed bed;

c. Qualifies as a Pediatric Specialty Hospital under the Medicaid Program, such that the hospital provides care exclusively to pediatric populations;

d. Has a percentage of Medicaid-eligible inpatient days relative to total inpatient days that equal or exceeds one standard deviation above the mean; and

e. Participates in the CICP.

The Major Teaching Hospital Rate is set by the Department such that the payment will not exceed the appropriation set by the General Assembly.

C. Provider Appeals

1. Any provider who submits an application to become a Qualified Health Care Provider whose application is denied may appeal the denial to the Department.

2. The provider's first level appeal must be filed within five business days of the receipt of the denial letter. The Department's Special Financing Division Director will respond to any first level appeals within ten business days of receipt of the appeal.

3. If a provider disagrees with the Department's Special Financing Division Director's first level appeal determination, they may file a second level appeal within five business days of the receipt of the first level appeal determination. The Department's Executive Director will respond to the second level appeal within ten business days of the receipt of the second level appeal.

D. Advisory Council

The Department shall create a CICP Stakeholder Advisory Council, effective July 1, 2017. The Executive Director of the Department shall appoint 11 members to the CICP Stakeholder Advisory Council. Members shall include:

1. A member representing the Department;

2. Three consumers who are eligible for the Program or three representatives from a consumer advocate organization or a combination of each;

3. A representative from a federally qualified health center as defined at 42 U.S.C. sec. 1395x (aa)(4) ~~(2020)~~;

4. A representative from a rural health clinic as defined at 42 U.S.C. sec. 1395x (aa)(2) ~~(2020)~~, or a representative from a clinic licensed or certified as a community health clinic by the Department of Public Health and Environment, or a representative from an organization that represents clinics who are not federally qualified health centers;

5. A representative from either Denver Health or University Hospital;

6. A representative from an urban hospital;

7. A representative from a rural or critical access hospital;

8. A representative of an organization of Colorado community health centers, as defined in the federal "Public Health Service Act", 42 U.S.C. sec. 254b ~~(2020)~~;

9. A representative from an organization of Colorado hospitals.

Members shall serve without compensation or reimbursement of expenses. The Executive Director shall at least annually select a chair for the council to serve for a maximum period of twelve months. The Department shall staff the council. The council shall convene at least twice every fiscal year according to a schedule set by the chair. Members of the council shall serve three-year terms. ~~Of the members initially appointed to the advisory council, the executive director shall appoint six for two-year terms and five for three-year terms.~~ In the event of a vacancy on the advisory council, the executive director shall appoint a successor to fill the unexpired portion of the term of such member.

The council shall

1. Advise the Department of operation and policies for the Program

2. Make recommendations to the Medical Services Board regarding rules for the Program

E. Annual Report

1. The Department shall prepare an annual report concerning the status of the Program to be submitted to the Health and Human Services committees of the Senate and House of Representatives, or any successor committees, no later than February 1 of each year.

2. The report shall at minimum include charges for each Qualified Health Care Provider, numbers of Clients served, and total payments made to each Qualified Health Care Provider.

10 CCR 2505-10 § 8.900 APPENDIX A: STANDARD CICP CLIENT COPAYMENT

A. Client Copayments - General Policies

A Client is responsible for paying a portion of his or her medical bills. The Client's portion is called the Client Copayment. Qualified Health Care Providers are responsible for charging the Client a copayment. Qualified Health Care Providers may require Clients to pay their copayment prior to receiving care (except for Emergency Care). Qualified Health Care Providers may charge copayments in accordance with the Standard Client Copayment Table or an alternate sliding fee scale that is submitted by the provider with the annual application for the CICP and approved by the Department.

Percent of FPL	0 - 40% and Homeless	0 - 40%	41 - 62%	63 - 81%	82 - 100%	101 - 117%	118 - 133%	134 - 159%	160 - 185%	186 - 200%	201 - 250%
Ambulatory Surgery	$0	$15	$65	$105	$155	$220	$300	$390	$535	$600	$630
Inpatient Facility	$0	$15	$65	$105	$155	$220	$300	$390	$535	$600	$630
Hospital Physician	$0	$7	$35	$55	$80	$110	$150	$195	$270	$300	$315
Emergency Room	$0	$15	$25	$25	$30	$30	$35	$35	$45	$45	$50
Emergency Transportation	$0	$15	$25	$25	$30	$30	$35	$35	$45	$45	$50
Outpatient Hospital Services	$0	$7	$15	$15	$20	$20	$25	$25	$35	$35	$40
Clinic Services	$0	$7	$15	$15	$20	$20	$25	$25	$35	$35	$40
Specialty Outpatient	$0	$15	$25	$25	$30	$30	$35	$35	$45	$45	$50
Prescription	$0	$5	$10	$10	$15	$15	$20	$20	$30	$30	$35
Laboratory	$0	$5	$10	$10	$15	$15	$20	$20	$30	$30	$35
Basic Radiology & Imaging	$0	$5	$10	$10	$15	$15	$20	$20	$30	$30	$35
High-Level Radiology & Imaging	$0	$30	$90	$130	$185	$250	$335	$425	$580	$645	$680

There are different copayments for different service charges. The following information explains the different types of medical care charges and the related Client Copayments under the Standard Client Copayment Table.

1. Inpatient facility charges are for all non-physician (facility) services received by a Client while receiving care in the hospital setting for a continuous stay of 24 hours or longer.

2. Ambulatory Surgery charges are for all non-physician (facility) Ambulatory Surgery operative procedures received by a Client who is admitted to and discharged from the hospital setting on the same day. The Client is also responsible for the corresponding Hospital Physician charges.

3. Hospital Physician charges are for services provided directly by a physician in the hospital setting, including inpatient, ambulatory surgery, and emergency room care.

4. Clinic Services charges are for all non-physician (facility) and physician services received by a Client while receiving care in the outpatient clinic setting. Outpatient charges include primary and preventive medical care. This charge does not include radiology or laboratory services performed at the clinic.

5. Emergency Room charges are for all non-physician (facility) services received by a Client while receiving Emergency Care or Urgent Care in the hospital setting for a continuous stay less than 24 hours (i.e., emergency room care).

6. Specialty Outpatient charges are for all non-physician (facility) and physician services received by a Client while receiving care in the specialty outpatient setting. These services can be provided in standalone clinics and outpatient hospital settings. Specialty Outpatient charges include distinctive medical care (i.e., oncology, orthopedics, hematology, pulmonary) that is not normally available as primary and preventive medical care. Specialty Outpatient charges do not include radiology, laboratory, emergency room, or ambulatory surgery services provided in a hospital setting.

7. Emergency Transportation charges are for transportation provided by an ambulance.

8. Laboratory Service charges are for all laboratory tests received by a Client while receiving care in the outpatient hospital or clinic setting. Laboratory Service charges may not be charged in addition to charges for emergency room or inpatient services provided in the hospital setting.

9. Basic Radiology and Imaging Service charges are for all radiology and imaging services received by a Client while receiving care in the outpatient hospital or clinic setting. Basic Radiology and Imaging Service charges may not be charged in addition to charges for emergency room or inpatient services provided in the hospital setting.

10. Prescription charges are for prescription drugs received by a Client at a Qualified Health Care Provider’s pharmacy as an outpatient service. To encourage the availability of discounted prescription drugs, providers are allowed to modify (increase or decrease) the Prescription Copayment with the written approval of the Department.

11. High-Level Radiology and Imaging Service charges are for Clients receiving a Magnetic Resonance Imaging, Computed Tomography, Positron Emission Tomography or other Nuclear Medicine services, Sleep Studies, or Catheterization Laboratory in the outpatient hospital, emergency room, or clinic setting.

12. Outpatient Hospital Service charges are for all non-physician (facility) and physician services received by a Client while receiving non-Emergency Care or non-Urgent Care in the outpatient clinic setting. Outpatient Hospital Services charges include primary and preventive medical care. This charge does not include radiology, laboratory, emergency room, or ambulatory surgery services provided in a hospital setting.

13. Clients who are seen in the hospital setting in an observation bed should be charged the emergency room copay if their stay is less than 24 hours and the inpatient facility copay if their stay is 24 hours or longer.

B. Homeless Clients, Clients living in transitional housing, “doubled-up” Clients, or recipients of Colorado’s Aid to the Needy Disabled financial assistance program, who are at or below 40% of the Federal Poverty Level are exempt from Client Copayments.

1. Homeless Clients are exempt from Client Copayments, the income verification requirement, and providing proof of residency when completing the CICP application.

2. Transitional housing is designed to assist individuals in becoming self-supporting. Clients living in transitional housing must provide a written statement from their counselor or program director asserting that they are participating in a transitional housing program. Transitional housing Clients are exempt from the income verification requirement when completing the CICP application.

3. Clients who have no permanent housing of their own and who are temporarily living with a person who has no legal obligation to financially support the Client are considered doubled-up. The individual allowing the Client to reside with him or her may be asked to provide a written statement confirming that the Client is not providing financial assistance to the household and that the living arrangement is not intended to be permanent.

4. Recipients of Colorado’s Aid to the Needy Disabled financial assistance program are exempt from Client Copayments, and the income verification requirement when completing the CICP application.

C. Client Annual Copayment Cap

1. Homeless Clients whose financial determination is between 0 and 40% of the federal poverty level are exempt from copayments, so their copayment cap is $0. Clients whose financial determination is between 0 and 40% of the federal poverty level who are not homeless have a copayment cap that is the lesser of 10% of the family’s net income or $120. Clients who are also Old Age Pension Health and Medical Care Program clients have a copayment cap of $300 as mandated by Section 8.941.10. For all other CICP Clients, annual copayments shall not exceed 10% of the family’s financial determination.

2. Clients who are also Old Age Pension Health and Medical Care Program clients have annual copayment caps based on a calendar year. All other Client annual copayment caps (annual caps) are based on the Client’s date of eligibility.

3. Clients are responsible for any charges incurred prior to the determination of the Client’s financial eligibility.

4. Clients are responsible for tracking their CICP copayments and informing the provider in writing, including documentation, within 90 days after meeting or exceeding their annual cap. If a Client overpays the annual cap and informs the Qualified Health Care Provider of that fact in writing, the Qualified Health Care Provider shall reimburse the Client for the overpayment.

5. A CICP Client is eligible to receive a new determination if his or her financial or family situation has changed since the initial financial determination. CICP copayments made under the prior financial determination will not count toward a new CICP copayment cap and the Client's annual copayment cap resets when the Client completes a new application.

6. An annual cap applies only to charges incurred after a Client is eligible to receive discounted health care services and applies only to discounted services incurred at a CICP Qualified Health Care Provider, including services discounted under Hospital Discounted Care.

D. The Client must pay the lower of the copayment listed, the patient responsibility portion if the Client is insured, or actual charges. Payment plans must be offered to Clients and must follow the requirements set forth in Section 8.923 of the Hospital Discounted Care rule.

E. Clients shall be notified at or before time of services rendered of their copayment responsibility and available payment plan option.

F. Grants from foundations to Clients from non-profit, tax exempt, charitable foundations specifically for Client copayments are not considered other medical insurance or income. The provider shall honor these grants and may not count the grant as a resource or income.

8.920 Hospital Discounted Care

PURPOSE AND LEGAL BASIS

The Health Care Billing for Indigent Patients Act of 2021, C.R.S. § 25-3-501, et. seq., referred to as Hospital Discounted Care, establishes the maximum rate a Health Care Facility and Licensed Health Care Professional may bill low-income patients for Discounted Care provided in the hospital, requires written description of patient's rights, establishes patient appeals and complaint processes, and imposes requirements on hospitals before assigning or selling patient debt to a medical creditor or before pursuing collection action.

8.921 DEFINITIONS

A. Billing Statement means any patient-facing communication, whether electronic or in writing, that specifies an amount due for services and instructions for making payment.

B. Children's Basic Health Plan or the Child Health Plan *Plus* (CHP+) means the Children's Basic Health Plan as defined in Title 25.5, Article 8, C.R.S.

C. Colorado Indigent Care Program or CICP means the safety net program established in Title 25.5, Article 3, Part 1, C.R.S.

D. Department means the Department of Health Care Policy and Financing established pursuant to section 25.5-1-104, C.R.S.

E. Discounted Care means the amount a Provider may charge a Qualified Patient for Medically Necessary Health Care Services rendered.

F. Emergency Medicaid means short--term Medicaid coverage for eligible people who do not meet immigration or citizenship requirements for Medicaid and need treatment for life- and/or limb-threatening emergencies.

G. Federal Poverty Guidelines or FPG means a measure of income level issued annually by the United States Department of Health and Human Services. For Hospital Discounted Care, the FPG is updated annually every April 1.

H. Health Care Facility means a hospital licensed as a general hospital pursuant to Title 25, Article 3, Part 1, C.R.S., a hospital established pursuant to section 23-21-503, C.R.S. or section 25-29-103, C.R.S., any freestanding emergency department licensed pursuant to section 25-1.5-114, C.R.S., or any outpatient health care facility that is licensed as an on-campus department or service of a hospital or that is listed as an off-campus location under a hospital's license, but does not include a federally qualified health center as defined in the federal "Social Security Act", 42 U.S.C. sec. 1395x-(aa)(4), or a student-learning medical or dental clinic that is established for the purpose of student learning, offering Discounted Care as part of a program of student learning that is physically situated within a health sciences school.

I. Health Care Services has the same meaning as set forth in section 10-16-102-(33), C.R.S.

J. Impermissible Extraordinary Collection Action means initiating foreclosure on an individual's primary residence or homestead, including a mobile home, as defined in section 38-12-201.5-(5), C.R.S.

K. Licensed Health Care Professional means any health care professional who is registered, certified, or licensed pursuant to Title 12, C.R.S. or who provides services under the supervision of a health care professional who is registered, certified, or licensed pursuant to Title 12, C.R.S. and who provides Health Care Services in a Health Care Facility.

L. Medicaid means the Colorado Medical Assistance Act set forth in Title 25.5, Articles 4, 5, and 6, C.R.S.

M. Medical Creditor means any entity that attempts to collect on a medical debt, including a Provider or Provider's billing office, a collection agency as defined in section 5-16-103-(3), a debt buyer as defined in section 5-16-103-(8.5), C.R.S. and a debt collector as defined in 15 U.S.C. sec. 1692a (6).

N. Non-CICP Health Care Services means Health Care Services provided in a Health Care Facility for which reimbursement under the Colorado Indigent Care Program, established in Title 25.5, Article 3, Part 1, C.R.S. is not available.

O. Patient Contact Best Efforts means the process of communication efforts completed by the Provider to contact a patient. This includes phone calls, SMS messages, emails, and portal messages.

P. Permissible Extraordinary Collection Action means an action other than an Impermissible Extraordinary Collection Action that requires a legal or judicial process, including but not limited to placing a lien on an individual's real property, attaching or seizing an individual's bank account or any other personal property, or garnishing an individual's wages. A Permissible Extraordinary Collection Action does not include the attachment of a hospital lien pursuant to section 38-27-101, C.R.S.

Q. Provider means any Health Care Facility or Licensed Health Care Professional subject to Title 25.5, Article 3, Part 5, C.R.S.

R. Qualified Patient means an individual who resides in Colorado, whose household income is not more than two hundred fifty percent of the Federal Poverty Level, and who received a Health Care Service at a Health Care Facility.

S. Screen or Screening means a process identified in rule by the Department whereby Health Care Facilities assess a patient's circumstances related to eligibility criteria and determine whether the patient is likely to qualify for public health care coverage or Discounted Care, inform the patient of the Health Care Facility's determination, and provide information to the patient about how the patient can enroll in public health care coverage.

T. SMS means short messaging service messages, commonly referred to as text messages

U. Uninsured means an uninsured individual, as defined in section 10-22-113-(5)(d), C.R.S.

8.922 SCREENING AND APPLICATION

A. Screening, Application, and Determination Notice

1. Beginning September 1, 2022, using the single uniform application developed and distributed by the Department, a Health Care Facility shall screen~~,~~ each uninsured patient and any insured patients who request to be screened for:

a. Public health insurance programs including but not limited to Medicare, Medicaid, Emergency Medicaid, and the Children's Basic Health Plan.

b. Eligibility for the CICP, if the patient receives or is scheduled to receive a service eligible for reimbursement through the CICP.

c. Discounted Care, as described in section 25.5-3-503, C.R.S.

2. Uninsured Patients

a. Health Care Facilities must complete the screening process using the uniform application within 45 days from the uninsured patient's date of service or date of discharge, whichever is later.

b. The screening process consists of completing the first page of the uniform application using self-attested information provided by the patient or their guardian.

c. If the self-attested screening process results in a determination that the patient may be eligible for Discounted Care, then, at the time of the screening, the Health Care Facility must provide the patient or their guardian with a list of information and documents required to complete the application process. The patient is permitted 45 days to provide the documentation required to complete the application. When all necessary documentation has been received from the patient, the Health Care Facility must determine the patient's eligibility for Discounted Care and send written notice of the determination to the patient or guardian within 14 days.

d. If the self-attested screening process results in a determination that a patient likely is ineligible for Discounted Care, the patient must be informed that the screening results are not an official determination and that they have the right to complete the application and receive an official determination of eligibility for Discounted Care if they choose. If the patient requests to complete the application process for Discounted Care, the Health Care Facility must complete the application process and provide an official determination of eligibility for Discounted Care.~~may request to complete the application process and receive an official determination of eligibility for Discounted Care~~.

e. If the self-attested screening process results in a determination that the patient may be eligible for one or more public health coverage options, the Health Care Facility must inform the patient of those options and provide information on how the patient may apply for them, including any application deadlines the patient should be aware of.

3. Insured Patients

a. If the insured patient or their guardian requests to be screened for public health insurance programs, CICP, and Discounted Care, Health Care Facilities must screen insured patients within 45 days of their date of service or date of discharge, or within 45 days of the date of their first bill after their insurance adjustment, whichever is later.

b. The request to be screened may be made in person, by telephone, email, or by using the portal, if available. Health Care Facilities must contact the insured patient or their guardian to schedule the screening within three business days after receiving the insured patient's request.

c. Patients believed to have health insurance coverage when services were rendered and who are subsequently determined to be uninsured on their date of service are considered Uninsured. Within 45 days from the date of the notification that the patient was not insured on the date of service, ~~T~~the Health Care Facility must complete the screening.

4. Health Care Facility Determination Notice

a. The Health Care Facility must provide the patient written notice of the determination within 14 days of ~~the determination of the patient's eligibility~~receiving all required documentation to complete the patient's application for Discounted Care. A copy of the determination must be sent to any and all applicable Licensed Health Care Professionals.

b. The determination shall be written in plain language and in the patient or their guardian's preferred language.

c. If a Health Care Facility fails to issue written notice of the determination to the patient within 14 days of receiving all required documentation to complete the patient's application, the patient may file an appeal. If the appeal is filed within 60 calendar days of the patient submitting all required documentation, the Health Care Facility must review the appeal and respond to the patient or their guardian and the Department within 15 calendar days of the date of the appeal.~~If no determination notice is received, an appeal letter must be submitted within 45 calendar days of the date the application was completed~~

~~e~~d. For patients determined to be eligible for Discounted Care, the determination notice must include but is not limited to:

1. The ~~determination of eligibility or ineligibility for the various~~ programs and discounts for which the patient was determined likely eligible for, including but not limited to Medicaid, Emergency Medicaid, CHP+, Medicare, ~~subsidies through Connect for Health Colorado,~~ Hospital Discounted Care, and CICP, and the availability of subsidies through Connect for Health Colorado. This must also include where to find

additional information and how to apply for each program the patient was determined potentially eligible for.

i. If the patient appears likely eligible for a program, and there is a deadline by which the patient must apply for to that program for their services to be covered, that date must be included in the determination notice.

2. The ~~service date the determination covers~~dates for which the Discounted Care determination is valid.

3. The household size and income used to determine eligibility and the household calculated FPG.

4. The patient's 4% and 2% limits based on their calculated gross household income.

5. If the patient was applying and approved for CICP, the patient's CICP rating.

6. If the patient was applying and approved for CICP, the patient's CICP copay cap.

7. If the Health Care Facility is not a CICP Provider, information on where the patient may obtain CICP services.

8. Information on how to file a complaint ~~or~~and how to file an appeal with the Health Care Facility and the Department.

~~d~~e. The determination notice for patients determined not eligible for Discounted Care must include but is not limited to:

1. The basis for denial of Discounted Care.

2. The ~~determination of eligibility or ineligibility for the various~~ programs and discounts for which the patient was determined likely eligible for, including but not limited to Medicaid, Emergency Medicaid, CHP+, Medicare, and the availability of subsidies through Connect for Health Colorado. This must also include where to find additional information and how to apply for each program the patient was determined potentially eligible for.

i. If the patient appears likely eligible for a program, and there is a deadline by which the patient must apply to that program for their services to be covered, that date must be included in the determination notice.

3. The service date the Discounted Care denial~~termination~~ covers and an explanation that the household may qualify for coverage of future services if there is a change in household size or income.

4. The household size and income used to determine eligibility and the household calculated FPG.

5. Information on how to file a complaint ~~or~~and how to file an appeal with the Health Care Facility and the Department.

5. A Health Care Facility is no longer obligated to screen an uninsured patient for past dates of service if the patient or their guardian signs the Decline Screening Form developed by the Department that notes those specific dates of service or a past date range that includes those specific dates of service except when a patient or guardian who opted out of screening subsequently requests to complete the screening, if the subsequent request is made prior to starting Permissible Extraordinary Collections Actions.

   a. The Health Care Facility must keep on file a Decline Screening Form signed by the patient, or their guardian until June 30 of the seventh state fiscal year after the patient's date of service or date of discharge, whichever is later.

6. For patients who are discharged without being screened or signing the Decline Screening Form, the Health Care Facility must attempt to contact the patient by at least one method of contact that the patient indicates is their preferred method, which can include phone call, SMS message, email, and portal message at least once a month for six months after the patient's date of discharge with the first contact sent prior to the expiration of 45 days after screening. The Health Care Facility may commence billing 46 days after the patient's date of service or date of discharge, whichever is later. If the patient requests that the Health Care Facility cease contacting them by phone, SMS message, or email, the provider may consider those requirements as fulfilled. The Health Care Facility must document the patient's request and maintain the request as part of the patient record.

7. If a Health Care Facility has attempted to contact the patient in accordance with Patient Contact Best Efforts, and the patient does not respond within 182 days of their date of service or date of discharge, whichever is later, the Facility may conclude that the patient has made an informed decision to decline screening. Patient Contact Best Efforts, at a minimum, must include:

   a. Notice that the failure to respond may result in the loss of their right to be screened for cost saving options.

   b. Calling any phone numbers provided by the patient and leaving ~~detailed~~ voice messages with allowable information under the Health Insurance Portability and Accountability Act as defined at 45 C.F.R. sec. 164.502 and the Telephone Consumer Protection Act as defined at 47 U.S.C. sec. 227 if the calls are unanswered,

   c. SMS messages to any of the patient's phone numbers identified by the patient as a mobile number if the Health Care Facility has the ability to send SMS messages,

   d. Sending emails to any email address provided by the patient, and

   e. Sending messages through any appropriate patient portal. ~~the patient has access to.~~

8. If a patient does not indicate their preferred method of contact, the Provider shall contact patients in accordance with their internal patient communication policies. Documentation of the communication attempts for patients must be kept in their patient records and the communication policy must be kept on file until the June 30 of the seventh state fiscal year past the patient's date of service.

9. Documentation of the attempts to contact the patient or guardian to complete the screening must be maintained as part of the patient record. This may include call logs, message logs, copies of sent emails, portal messages sent, and copies of bills.

~~9~~10. Providers shall maintain all Discounted Care-related records, including but not limited to, documentation to support screenings and determinations, service data including dates of service for Qualified Patients and services provided to them on those dates, and expenditures until June 30 of the seventh state fiscal year following the creation of the documentation.

B. Patients

1. Any patient or patient's guardian aged 18 and older may apply to receive Discounted Care.

2. The decision regarding eligibility for Discounted Care applies to both the patient and the members of the patient's household.

3. If a patient is deceased, the personal representative of the estate or a family member may complete the screening and application on behalf of the patient.

4. The application to receive Discounted Care shall include the names, birth dates, and relationship to the patient of all members of the patient's household who are included on the application.

   a. A patient must include their spouse or civil union partner in their household for the application.

   b. Any additional person living at the same address as the patient may also be included in the household.

   c. A patient may include household members who live in other states or countries if the patient attests to the fact that they provide at least 50% of the household member's support.

5. A minor shall not be screened separately from his or her parents or guardians unless they are emancipated or there exists a special circumstance. A minor is an individual under the age of 18.

C. Household Income

1. Using the information submitted by a patient or patient's guardian, the Health Care Facility shall determine whether the patient meets all requirements to receive Discounted Care. Health Care Facilities must follow the income counting methodology determined by the Department. Health Care Facilities shall determine Qualified Patient financial eligibility based on income from each household member 18 and older and household size. The Health Care Facility may not consider assets in determining eligibility.

2. Eligibility shall be determined at the time of application, unless required documentation is not available, in which case the patient or patient's guardian will be notified of the missing documentation within three business days after receipt of the application. An eligibility determination shall be made within 14 calendar days after the application is complete.

3. Patients may establish household income by providing documents that satisfy documentation guidelines established by the Department. Acceptable forms of

documentation ~~Documentation required to establish household income~~ may include but is not limited to pay stubs, employer letter, tax returns, and business financial statements. The Health Care Facility may not require more than the minimum amount of documentation to substantiate declared income.

a. Patients who are experiencing homelessness are exempt from the documentation requirements related to establishing income and may self-attest to their household income.

8.923 HEALTH CARE SERVICE DISCOUNTS

A. Beginning September 1, 2022, if a patient screened pursuant to section 8.922 is determined to be a Qualified Patient, a Health Care Facility and a Licensed Health Care Professional shall:

1. Limit the amounts billed for Health Care Services to no more than the rate established in Department rule pursuant to section 8.929

2. Enter into a payment plan with the Qualified Patient in which the Qualified Patient pays for care in monthly installments. For services provided by a Health Care Facility, monthly installments shall not exceed four percent of the patient's gross monthly household income. For services provided by each Licensed Health Care Professional who bills separately from the Health Care Facility, monthly installments shall not exceed two percent of the patient's gross monthly household income; and

3. After a cumulative thirty-six months of payments, ~~T~~the Health Care Facility shall treat the Qualified Patient's bill as paid in full and must permanently cease collection activities on any balance that remains unpaid.

4. Providers shall not suggest or require that patients obtain loans that include fees, interest, or payment plans that exceed 36 payments to pay for services in lieu of setting up a payment plan directly with the Health Care Facility or Licensed Health Care Professional. ~~This includes loans from banking institutions and other creditors, like CareCredit.~~

a. If a patient defaults on a loan from the Provider, the same rules apply related to any collection actions taken by the Provider as apply for payment plans under this section. If a patient defaults on a loan from the Provider, the same rules apply related to any collection actions taken by the Provider as apply for payment plans under this section.

B. A Health Care Facility shall not:

1. Deny Discounted Care on the basis that the patient has not applied for any public benefits program; or

2. Adopt or maintain any policies that result in the denial of admission or treatment of a patient because the patient may qualify for Discounted Care.

8.924 PATIENT RIGHTS

A. Beginning September 1, 2022, a Health Care Facility shall make available to the public and to each patient information developed by the Department about patient's rights pursuant to Part 5 of Article 3 of Title 25.5 C.R.S. (2021) and the uniform application developed by the Department pursuant to section 25.5-3-505 (2)(i), C.R.S.

B. At a minimum, the Health Care Facility shall:

1. Post the information in all languages spoken by ten percent or more of the population in any Colorado county conspicuously on the Health Care Facility's website, including a link to the information on the Health Care Facility's main landing page;

2. Make the information available in patient waiting areas;

3. Make the information available to each patient, or the patient's legal guardian, before the patient is discharged from the Health Care Facility, verbally or in writing in the patient's or legal guardian's preferred language, which may include using professional interpretation and/or translation services; and

4. Inform each patient on the patient's Billing Statement of the patient's rights pursuant to Part 5 of Article 3 of Title 25.5, C.R.S. (2021) including the right to apply for Discounted Care, and provide the website, email address, and telephone number where the information may be obtained in the patient's preferred language.

C. Providers shall not present the patient's rights in a format that differs from the format in which the material is distributed by the Department without Department approval.

1. Providers may not make any part of the patient's rights information part of a footnote or use any other format that may minimize its importance.

8.925 REPORTING REQUIREMENTS

A. Beginning September 1, 2023, and each September 1 thereafter, each Health Care Facility shall report to the Department data that the Department determines is necessary to evaluate compliance across race, ethnicity, age, and primary-language-spoken patient groups with the screening, Discounted Care, payment plan, and collections practices required by Title 25.5, Article 3, Part 5, C.R.S. (2021). The Department shall distribute a compliance data reporting template to each Health Care Facility.

1. If a Health Care Facility is not capable of disaggregating the required data by race, ethnicity, age, and primary language spoken, the Health Care Facility shall report to the Department the steps the Health Care Facility is taking to improve race, ethnicity, age, and primary language spoken data collection and the date by which the facility will be able to disaggregate the reported data.

B. Beginning September 1, 2023 and each September 1 thereafter, each Health Care Facility shall submit Discounted Care utilization and charge data in a format and timeline determined by the Department.

8.926 COLLECTIONS

A. Beginning September 1, 2022, before assigning or selling patient debt to a collection agency or a debt buyer, or before pursuing, either directly or indirectly, any Permissible Extraordinary Collection Action:

1. A Health Care Facility shall meet the screening requirements in section 8.922;

2. A Provider shall provide Discounted Care to a Qualified Patient pursuant to section 8.920;

3. A Provider shall provide a plain language explanation of the health care services and fees and notify the patient or their guardian of potential collection actions in their preferred language on the timeline developed by the Department; and

4. A Provider shall bill any third-party payer that is responsible for providing health care coverage to the patient. If a Licensed Health Care Professional is an out-of-network provider under a Qualified Patient's health insurance plan, the Licensed Health Care Professional and health insurance carrier shall comply with the out-of-network billing requirements described in sections 10-16-704 (3) and 12-30-113, C.R.S.

B. A Health Care Facility must complete the Patient Contact Best Efforts in their attempts to contact a patient who has not signed a Decline Screening Form or who has not been screened as described in Section 8.922 prior to starting Permissible Extraordinary Collections Actions.

C. Documentation of Patient Contact Best Efforts communication attempts with the patient as outlined in section 8.922 satisfies the screening requirements for Health Care Facilities.

D. For a Qualified Patient with an established payment plan, Permissible Extraordinary Collections Actions may not be started until the patient has failed to remit three consecutive payments and has not communicated with the Provider asking for a deferment or to be redetermined prior to or during those three months of missed payments. Providers must notify Qualified Patients with established payment plans at least 30 days prior to the commencement of Permissible Extraordinary Collections Actions.

E. Providers shall not commence collection proceedings against a patient for any amount in excess of the rates established at Section 8.923.A.2, and must reduce the amount owed by the amount of any payments received from the patient or a third-party payer.

8.927 APPEALS AND COMPLAINTS

A. If a patient is determined ineligible for Discounted Care after the uniform application has been completed, the patient may appeal the decision as follows:

1. No later than 30 calendar days from the date on the Health Care Facility's eligibility determination letter, the patient or their guardian may submit an appeal in writing via U.S. Mail, email, or patient portal message if available to the Health Care Facility that made the determination.

2. Within 15 calendar days from the date of the appeal, the Health Care Facility shall complete a redetermination of eligibility and respond to the patient or guardian and the Department.

3. If the Health Care Facility upholds its initial eligibility determination, the patient or guardian may proceed to the next step of the appeals process as described in Section 8.927.A.4.

4. No later than 15 calendar days from the date of the Health Care Facility's initial appeal decision, the patient shall submit a written appeal to the Department. Email submissions must be addressed to hcpf_HospDiscountCare@state.co.us. Letters must be mailed to:

Department of Health Care Policy and Financing
Attention: Hospital Discounted Care
c/o State Programs Unit, Special Financing Division
1570 Grant Street
Denver, CO 80203

5. Within 15 calendar days from date of receipt of the appeal, the Department shall issue a final determination letter to both the patient and the Health Care Facility. If the Department deems that the redetermination was inaccurate, the Health Care Facility must resend a determination letter to the patient and the Department stating the patient is/was eligible for Discounted Care on the date of service.

B. A patient or guardian who believes a Health Care Facility has improperly calculated a payment plan based on inaccurate income information may appeal the payment plan offered by the Facility to the Department using the process described in Section 8.927.A.1.

C. The Department shall maintain records of all appeals and its final determinations for each Health Care Facility. If the Department determines a Health Care Facility has a repeated pattern of errors in patient eligibility determinations, the Department will require the Health Care Facility to attend training with the Department. The Health Care Facility may be subject to random application checks for 12 months following the training to ensure that the errors have been corrected.

D. Patients and their guardians may file complaints against Providers directly with the Department. Patients are not required to file a complaint with the Provider prior to filing a complaint with the Department.

1. Patients may submit complaints via U.S. Mail, email, or phone as follows:

Phone: 303-866-2580
Email: hcpf_HospDiscountCare@state.co.us
U.S. Mail: Department of Health Care Policy and Financing
Attention: Hospital Discounted Care
c/o State Programs Unit, Special Financing Division
1570 Grant Street
Denver, CO 80203

2. The Department shall review complaints within 30 calendar days of receipt.

3. The Department shall maintain records of all complaints for each Provider. If the Department determines there is a repeated pattern in the complaints filed against the Provider, the Provider may be subject to a corrective action plan.

a. Providers will have 90 days to submit a corrective action plan. Extensions may be made at the Department's discretion up to no more than 120 days.

8.928 REVIEW OF PROVIDERS FOR NONCOMPLIANCE

A. The Department shall periodically review Providers to ensure compliance with Part 5 of Article 3 of Title 25.5, C.R.S. (2021) and these rules. If the Department finds that a Provider is not in compliance with these rules, the Department shall notify the Provider.

B. The Provider will have 90 days to file a corrective action plan with the Department that must include measures to inform impacted patients about the noncompliance and provide financial corrections consistent with these rules.

1. At the Department's discretion, a Provider may be permitted up to 120 days to submit a corrective action plan upon request.

2. The Department may require a Provider that is not in compliance with Title 25.5, Article 3, Part 5, C.R.S. or these rules to develop and operate under a corrective action plan until the Department determines the Provider is in compliance.

C. If a Provider's noncompliance with these rules is determined by the Department to be knowing or willful or there is a repeated pattern of noncompliance, the Department may fine the Provider no more than $5,000. If the Provider fails to take corrective action or fails to file a corrective action plan with the Department pursuant to this section, the Department may fine the Provider no more than $5,000 per week until the Provider takes corrective action. The Department shall consider the size of the Health Care Facility and the seriousness of the violation in setting the fine amount.

D. The Department shall make the information reported pursuant to this section and any corrective action plans for which fines were imposed pursuant to this section available to the public and shall annually report the information as part of its presentation to its committees of reference at a hearing held pursuant to section 2-7-203 (2)(a), C.R.S. of the "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act".

E. For audit purposes, Providers shall maintain all Discounted Care related records, including but not limited to, documentation to support screenings and determinations, service data including dates of service for Qualified Patients and services provided to them on those dates, and expenditures until June 30 of the seventh state fiscal year following the screening or determination.

8.929 RATES

The Department shall annually establish rates for Discounted Care. The rates will approximate and not be less than one hundred percent of the Medicare rate or one hundred percent of the Medicaid rate, whichever is greater. The Department shall publicly post the established rates on the Department's website pursuant to section 25.5-3-505, C.R.S.

8.930 [Repealed effective 8/12/2011.]