COLORADO
Department of Health Care Policy & Financing

MINUTES
Hospital Discounted Care Advisory Committee
Department of Health Care Policy & Financing

Join Zoom

October 27, 2025
1:00 to 3:00 P.M.

1. **Welcome and Introductions**
   - ➢ Sarah Irons, Chair, and Taryn Graf, HCPF 1:00 to 1:10 P.M.
   - ➢ Members Present: Milena Tayah, Sophia Hennessy, Kelly Erb Zager, Erin Varnum, Christopher Alverez, Bernadette O'Keefe, Diane Lawson, Megan Axelrod, Sarah Irons, Enrique Lujan
   - ➢ Members Excused: Talonnie Granger
   - ➢ HCPF Employees Present: Taryn Graf, Chandra Vital, Shannon Huska, Daniel Harper, Sam Mateer, Nick Pontejos, Sean Pocock, Rick Love
2. **Meeting Minutes**
   - ➢ There was a typo of a first name in the presented minutes. Christopher Alvarez made a motion to approve the adjusted minutes. Erin Varnum seconded. The minutes were approved.
3. **Licensed Health Care Professional Groups**
   - ➢ Taryn Graf, HCPF, 1:10 to 1:19 P.M.
   - ➢ Taryn Graf said at the July meeting, we discussed concerns from Professional groups about difficulties obtaining information from hospitals for approved patients and issues with the new separate data submission requirement. Now that the data has been received, we have a clearer picture of the challenges these groups are facing. Today, data team members Daniel Harper and Sam Mateer will present an overview of this year's Professional submissions.
   - ➢ Sam Mateer presented an overview of the data challenges identified in the professional submissions required under the Hospital Discounted Care law (Senate Bill 24-116). They outlined four primary issues:

- Structural Data Gap: Hospitals collect demographic data during screenings, but many professionals do not. This creates mismatches that require manual data entry and often result in unmatchable records when facility medical record numbers do not align.
- Administrative Impact: When data imports fail, professionals and facilities must manually exchange missing information. This process increases administrative burden for both parties and delays reporting within HCPF's tight review timelines.
- Data Quality Concerns: Roughly 17% of patient submissions lacked demographic data entirely. Ethnicity data was unknown for about 58% of professional submissions compared to only 7.4% in facility data, highlighting breakdowns in demographic data transfer and affecting compliance and equity analysis.
- Compliance and Awareness: Some professionals remain uncertain about how reporting requirements apply to them, contributing to underreporting and incomplete billing. Gaps in communication between facilities and professionals appear to be a significant factor.

➢ Sam Mateer emphasized that identifying where these disconnects occur—whether in facility reporting, professional data handling, or communication—is critical to improving data quality and ensuring compliance.

➢ Taryn Graf noted that only a small number of Professional groups submitted data this year, suggesting that many may still be unaware of their reporting obligations under the Hospital Discounted Care law. She clarified that professionals providing services within hospitals to Hospital Discounted Care patients must follow the associated billing, payment plan, and collections policies, even if they operate independently. Services provided in their own clinics are not subject to these requirements.

- Beginning with the next submission cycle, due September 1, 2026, hospitals will be required to report the Professional groups that provide services within their facilities. Although previously optional, this data will help HCPF identify and contact groups to ensure compliance and understanding of responsibilities.

➢ Taryn Graf reiterated ongoing issues reported by Professional groups, including:

- Difficulty contacting the correct hospital staff to obtain patient information.
- Limited access to or inability to store demographic data.
- Burdensome manual processes for sorting large hospital data files.
- Restrictions on system access that hinder efficient information retrieval.

➢ Taryn Graf said that HCPF has implemented some partial solutions, such as allowing professionals to include hospital Medical Record Numbers (MRNs) in lieu of demographics so HCPF can match the data from hospital submissions. However, success with this approach has been inconsistent. Another partial solution is HCPF having collected an identified dedicated hospital contact for each hospital facility that can be connected with professional groups needing Hospital Discounted Care patient information.

➢ Taryn Graf stated that communication and data-sharing remain the most challenging aspects, with no current solution in place. She invited feedback from the Committee and attendees to explore potential efficiencies and process improvements for both hospitals and professionals.

➢ Committee Discussion, 1:19 to 1:57 P.M.

➢ Bernadette O'Keefe asked whether the hospital reporting template submitted to HCPF requires Medical Record Numbers (MRNs) or if hospitals determine what information to include.

➢ Taryn Graf clarified that the data template created and maintained by Sam and Daniel's team does require MRNs. However, a recurring issue has been that professionals are submitting MRNs obtained from hospitals that do not appear in the hospitals' own data submissions.

➢ Taryn Graf noted the cause of this discrepancy is unclear—it could stem from miscommunication between hospitals and professionals or from certain patients being inadvertently excluded from hospital reports.

➢ Megan Axelrod noted that the ongoing challenges with data access appear to stem from communication gaps between hospitals and professionals, where each side lacks visibility into the other's processes. She asked whether the issues were occurring across the board or concentrated among specific organizations.

- Sam Mateer explained that the challenges are widespread across both facilities and professional groups, with varying degrees of success in data submission. Some professionals provided complete demographic data, while others relied on data imports from hospitals that only partially worked due to missing or mismatched Medical Record Numbers (MRNs). Sam described using an XLOOKUP formula to match MRNs between hospital and professional submissions, and noted that errors occur when a professional's MRN does not appear in the hospital's dataset.

- Megan Axelrod confirmed her understanding and offered that the Colorado Hospital Association (CHA) could assist by facilitating communication between hospitals and professionals to help resolve these disconnects.

- Bernadette O'Keefe suggested that professionals might be mistakenly submitting their own MRNs rather than the hospital MRNs, which could be causing mismatches. Sam Mateer clarified that the data submission template includes distinct fields for both the professional's internal MRN and the hospital's MRN. The hospital MRN field is optional only when professionals provide the full set of demographic data themselves. While Bernadette O'Keefe's theory was possible, Sam Mateer noted that the mismatches did not seem to follow a consistent pattern.

- Christopher Alvarez asked whether making the hospital MRN a required field could help reduce errors. Sam Mateer explained that it is already conditionally required—professionals must either provide the hospital MRN or include the full demographic details directly in their submissions.

- Sarah Irons shared that Children's Hospital Colorado has been partnering with CU Med to ensure complete and accurate data sharing for Hospital Discounted Care patients. She asked whether other facilities were taking similar approaches. Sam Mateer responded that practices vary widely: some professionals have access to hospital electronic health record (EHR) systems but may not know how to use them effectively, while others rely on faxed or emailed patient lists.

- Taryn Graf added that hospitals use a range of methods for data sharing—fax, email, or direct EHR access—depending on what each professional group can accommodate. This inconsistency, along with large patient data files, creates a heavy manual workload throughout the year.

- Megan Axelrod agreed, emphasizing that the wide variety of EHR systems, staffing shortages, and limited resources—especially in rural hospitals—make consistent implementation difficult.

- Diane Lawson asked whether smaller provider groups were experiencing the greatest challenges. Taryn Graf responded that both small and large professional groups are affected, although the specific difficulties often depend on the hospital involved. She noted that some groups have strong systems with one hospital but face major barriers with others.

- Megan Axelrod reiterated that the Colorado Hospital Association is willing to facilitate direct communication between hospitals and professionals to help improve data coordination. Taryn Graf thanked her and noted that while HCPF now has contact information for hospitals, the problem remains broader than what the Department can address alone.

- Bernadette O'Keefe asked whether HCPF had reached out directly to hospitals or providers with known data gaps to better understand their challenges. Sam Mateer said that outreach is conducted when issues arise, and HCPF has occasionally connected professionals directly with hospital contacts. However, they added that confusion persists, with some professionals still unaware that the Hospital Discounted Care law applies to them—underscoring the need for clearer communication and education.

- Diane Lawson suggested identifying provider groups that have been successful in accurate and timely data submissions and documenting their best practices to help other groups improve compliance and reporting efficiency.

- Christopher Alvarez raised the possibility that differences among hospitals' electronic health record (EHR) systems—and the fact that professionals use their own systems with varying data capabilities—might be contributing to the reporting and data import problems.

- Sam Mateer agreed this was likely a contributing factor and added that HCPF has not yet reached out to the professionals who experienced no issues with data imports. They noted this would be a valuable next step to identify successful practices that could inform improvements going forward.

- Daniel Harper supported this approach, suggesting that now that the data submissions are complete, HCPF should both review providers who were successful

and reach out to those who struggled. He said this two-pronged review would help the department plan for next year's reporting cycle.

- Sarah Irons proposed revisiting this topic at the next meeting, once the compiled data is available, to determine whether the challenges stem from EHR issues or outdated data-sharing methods such as faxing. She encouraged identifying specific professional groups that may need one-on-one support.

- Taryn Graf asked if any participants had examples of successful processes or challenges they wanted to share before moving to the next topic.

- Bernadette O'Keefe shared that Denver Health had significant difficulty submitting data this year, particularly due to unclear instructions for certain data fields. She said her team went back and forth with HCPF staff, including Nick Pontejos, to resolve these issues and suggested that clarifying instructions might reduce confusion for other hospitals.

- Taryn Graf responded that the department continually works to improve the data template and its instructions while avoiding unnecessary changes from year to year, as major revisions can create new challenges for facilities. She invited Daniel Harper, Sam Mateer, and Nick Pontejos to add comments.

- Daniel Harper emphasized that HCPF values feedback from providers on what works and what doesn't. He encouraged facilities to share their input through the Hospital Discounted Care data inbox, which the department monitors for next year's updates.

- Nick Pontejos confirmed that he is already maintaining a list of potential template improvements and welcomed additional suggestions from facilities.

- Jessica Portillo from Estes Park Health shared that her facility communicates with external providers primarily via fax. However, she often receives responses from clinics stating they are not part of Hospital Discounted Care and therefore believe the requirements do not apply to them. She noted this communication disconnect—possibly sending materials to the wrong departments in the facilities—has made coordination difficult.

- Taryn Graf agreed and emphasized the importance of connecting the correct hospital and professional contacts. She mentioned that HCPF maintains a FAQ for professionals available on the department's website and said she would include it in the next newsletter. Taryn Graf encouraged hospitals to distribute the FAQ to

professionals who believe Hospital Discounted Care requirements do not apply to them.

- ➢ Jessica Portillo agreed this would be helpful, and Taryn Graf confirmed that the FAQ link would be sent out in the next HCPF newsletter to help professional groups better understand their responsibilities under the program.

- ➢ Taryn Graf added one final topic for discussion. A professional group had contacted her team with questions about backdating timelines for Hospital Discounted Care determinations. The group received a data set from a hospital showing a patient's eligibility backdated nearly two years and was unsure how far back professionals are required to apply discounts in such cases.

- ➢ Taryn Graf explained that the standard policy is a 181-day backdate from the date of application. However, the application date is not currently included on the Hospital Discounted Care determination letters or patient cards, making it difficult for professionals and hospitals to know where the 181-day window begins. Some hospitals have chosen to extend backdating beyond that period, which adds to the confusion.

- ➢ Christopher Alvarez stated that facilities extending backdating beyond 181 days should handle those cases independently. He said all facilities should follow the 181-day rule unless they specifically choose to extend it and clearly communicate that decision to their professional partners.

- ➢ Sarah Irons commented that the broader issue involves communication—it does not matter whether the information is listed on a card or a letter if professionals never receive it. She recommended that the group focus on determining the most effective way to deliver this information to providers.

- ➢ Taryn Graf clarified that this issue affects both professionals and hospitals, since patients frequently receive care at multiple hospitals under one eligibility determination. Christopher Alvarez asked whether a facility must honor another hospital's extended backdating. Taryn Graf confirmed that it does not; each facility is responsible for following the 181-day standard from the application date, not from a prior hospital's decision.

- ➢ Taryn Graf further explained that the primary challenge is the absence of the application date in official materials, leaving professionals uncertain about where to begin their 181-day calculation. She suggested adding the application date to

the determination letters or Hospital Discounted Care cards to standardize communication across facilities.

- ➢ Christopher Alvarez supported the idea and emphasized that having the application date in writing would help both hospitals and professional services remain compliant and provide clear documentation in case of audits.

- ➢ Bernadette O'Keefe asked whether the two-year backdating case involved a recent application or an older one. Taryn Graf explained that it was a recently completed application that the hospital had chosen to backdate nearly two years. Bernadette O'Keefe said that in such cases, the provider should still apply the standard 181-day backdate from the date of referral. She agreed that any further extension should be negotiated directly between the hospital and the professional group.

- ➢ To resolve the issue, Taryn Graf proposed a vote on adding the application date to Hospital Discounted Care determination letters and patient cards. Sarah Irons led the vote, and the measure passed.

- ➢ Taryn Graf confirmed that the change will be incorporated into the Hospital Discounted Care manual and reflected on the patient card moving forward.

4. Decline Screening Form Updates

- ➢ Taryn Graf, HCPF, 1:57 to 2:01 P.M.

- ➢ Taryn Graf introduced proposed updates to the decline screening form. She reminded the committee that this discussion began at the July meeting. The purpose of the proposed revisions, she explained, is to reduce administrative burden for hospitals and decrease patient frustration by making the screening process clearer and more efficient.

- ➢ Taryn Graf noted that hospitals have reported patient complaints about feeling pressured to sign the decline screening form, with some patients describing the process as "harassing." She reiterated that verbal declines are valid under Hospital Discounted Care requirements. Hospitals simply need to document those verbal declines on the form to fulfill their screening obligation.

- ➢ Referencing data from the 2023–2024 Hospital Discounted Care Report, Taryn Graf explained that hospitals collectively reported nearly 366,000 patients during the period.

- ➢ Taryn Graf continued, detailing the breakdown of data from hospital submissions:

- Final determinations were reported for about 147,700 patients.
- Approximately 20,650 patients only had payment plan or collections information, likely representing cases from the previous year where payment activity continued into 2023–2024.
- Around 52,700 patients were insured but included without screening information, suggesting they were incorrectly reported.
- The remaining 144,651 patients were uninsured with no screening information included. These individuals likely represent the group that hospitals are required to contact for up to six months following their date of service.

➢ Taryn Graf explained that the proposed form updates are designed to reduce this unscreened patient pool by clarifying patient intent during intake. Some hospitals have already integrated the current decline screening form into their registration process. However, when forms are returned blank, it is unclear whether patients intentionally left the decline screening form blank because they want to be screened or if they simply skipped the form.

➢ To address this, the revised form adds an explicit option for patients to indicate that they want to be screened. This change would help hospitals identify patients willing to complete the screening process, allow earlier collection of necessary demographic information, and reduce both the number of follow-up contacts and administrative workload.

➢ Taryn Graf also noted two minor edits made since the last version of the form:

- The redundant words “or boxes” were removed from the instruction line (“please read and initial the appropriate box”).
- The words “and payment plans” were removed from both the “do” and “do not” screening options, since patients may set up payment plans without applying for financial assistance.

➢ She concluded by asking the committee for comments and feedback on the proposed form revisions, particularly regarding how the changes could help reduce administrative burden, streamline follow-up, and improve the patient experience.

➢ Committee Discussion, 2:01 to 2:13 P.M.

- Megan Axelrod thanked Taryn Graf for clarifying the intent of the decline screening form updates but expressed concern that adding both opt-in and opt-out options could increase confusion and paperwork for patients already facing numerous hospital forms. She cautioned that additional steps might unintentionally create more follow-up work for hospitals and agreed to gather feedback from the Colorado Hospital Association's members.

- Taryn Graf appreciated the input and clarified that no implementation timeline had been established yet. She said the committee would revisit the timing after further discussion and stakeholder feedback.

- Diane Lawson asked for clarification about patient timeframes for applying and submitting documentation. Taryn Graf explained that patients have 181 days from the date of service to request screening and an additional 45 days to provide required documentation. Hospitals then have 21 days to complete determinations. Diane confirmed her understanding of the process.

- Bernadette O'Keefe suggested formatting the "I DO" and "I DO NOT" selections on the form in all capital letters for clarity and recommended adding a date of birth field to help hospitals identify patients. Taryn Graf agreed to incorporate both changes if space allows.

- Taryn Graf also reiterated that the updated form would not change policy—it would only be required for patients who decline screening, helping hospitals integrate the form more easily into registration workflows.

- Erin Varnum proposed renaming the document, since it now includes a "Yes" option. Taryn Graf confirmed the title would be updated.

- Milena Tayah raised a concern about patients signing the form while incapacitated or under the influence. Taryn Graf explained that hospitals should not obtain screening forms in those circumstances and reminded the group that patients may reconsider and request screening later, even after initially declining.

- Megan Axelrod thanked Taryn Graf again and confirmed she would follow up with CHA hospitals to gather perspectives and report back.

- Bernadette O'Keefe recommended waiting for that feedback before deciding on an implementation timeline. The group agreed, and Taryn Graf said the topic would return to the January agenda for further discussion. Sarah Irons, as chair, supported that plan.

5. Addressing Compliance Issues

- ➢ Taryn Graf, HCPF, 2:14 to 2:16 P.M.

- ➢ Taryn Graf opened discussion on compliance issues, a topic requested at the July meeting. She explained that the Hospital Discounted Care statute directs HCPF to periodically review hospitals and professionals and require Corrective Action Plans (CAPs) when compliance problems are identified.

- ➢ HCPF's program audits team reviews eligibility and billing practices, and any provider with findings exceeding 10% in a category must submit a CAP. To date, 20 CAPs have been issued for audit findings and three for non-audit compliance issues. Taryn Graf emphasized that HCPF works closely with hospitals to resolve problems before resorting to formal CAPs, noting that only three non-audit plans in several years indicates strong overall compliance.

- ➢ The most frequent audit findings involve data reporting errors, missing documentation, and missed timelines for screenings or billing. HCPF uses audit results to shape training priorities—recently expanding education on data collection and refining reporting templates to reduce errors. Non-audit CAPs have addressed issues with determination notices and missing "allowed amount" data in submissions.

- ➢ Taryn Graf added that HCPF also investigates complaints from patients, advocates, and other providers. Facilities generally cooperate to correct identified issues and avoid the need for formal corrective plans.

- ➢ Committee Discussion, 2:16 to 2:20 P.M.

- ➢ Erin Varnum asked for clarification about CAPs and the audit process. Taryn Graf explained that a CAP is a structured plan outlining how a hospital will correct a problem, including the process changes, timelines, and implementation details. Hospitals have 90 days to submit their plan and 10 business days to respond to any follow-up questions.

- ➢ Erin Varnum then asked whether patient or advocacy complaints are included in audits. Taryn Graf clarified that complaints are handled separately through HCPF's inbox as they arise. The audits themselves focus on eligibility and billing accuracy—verifying proper screening documentation, correct charge amounts, and adherence to required timelines for billing and collections. However, repeated complaints about a facility can trigger further review or result in a CAP.

6. **Department Updates**
   - ➢ Taryn Graf, HCPF, 2:20 to 2:21 P.M.
   - ➢ Taryn Graf provided a brief department update. She reported that data was received from all 85 hospitals this year and is currently being combined for inclusion in the upcoming annual report. The Hospital Discounted Care Annual Report will be published by February 2, 2026, as February 1 falls on a weekend.
   - ➢ Taryn Graf added that HCPF will also present Hospital Discounted Care program information to the legislature during the department's SMART Government Act hearing—the State Measurement for Accountable, Responsive, and Transparent Government Act—which typically occurs in mid-January, though the official date has not yet been set.
   - ➢ She noted that links to the previous annual report and the SMART Hearing handout are available on the Hospital Discounted Care website.
   - ➢ Committee Discussion, 2:21 to 2:21 P.M.
   - ➢ There were no questions or comments about the Department Updates.
7. **Open Forum for Public Comment***
   - ➢ Public Comment 2:22 to 2:22 P.M.
   - ➢ There were no public comments.

*All comments will be limited to a maximum of two minutes unless scheduled in advance.

8. **Next Meeting**
   - ➢ Monday, January 26, 2026 from 1 to 3 P.M.
9. **Adjournment**
   - ➢ 2:23 P.M. – Megan Axelrod motioned to adjourn the meeting; Kelly Erb Zager seconded the motion.
   - ➢ Meeting adjourned at 2:23 P.M.

Reasonable accommodations will be provided upon request for persons with disabilities. Please notify the Board Coordinator at 303-866-5634 or Taryn.Graf@state.co.us or the 504/ADA Coordinator hcpf504ada@state.co.us at least one week prior to the meeting to make arrangements.