Hospital Discounted Care and Colorado Indigent Care Program (CICP) Operations Manual

Fiscal Year 2022-23

Section V: Hospital Discounted Care

Effective June 1, 2022

CICP
Colorado Indigent Care Program

Table of Contents

ARTICLE I. HB 21-1198 HOSPITAL DISCOUNTED CARE

Section 1.01 HB 21-1198 Hospital Discounted Care Overview

House Bill (HB) 21-1198 is also known as Health Care Billing for Indigent Patients Receiving Services Not Reimbursed Through Colorado Indigent Care Program (CICP) or Hospital Discounted Care. It establishes discounts for low-income patients, and it requires that all uninsured patients and all insured patients who request to be screened for eligibility for Health First Colorado, the Child Health Plan Plus (CHP+), Medicare, Emergency Medicaid, CICP and Hospital Discounted Care.

Health Care Facilities must screen each uninsured patient unless a patient declines to be screened. If requested by the patient, a Health Care Facility shall screen an insured patient.

HB 21-1198 established rules for Health Care Facilities and Licensed Health Care Professionals to limit collections against a qualified patient. A Health Care Facility and a Licensed Health Care Professional shall, for emergency and other non-CICP health care services:

- Limit the amount charged to not more than the discounted rate established in Colorado Department of Health Care Policy and Financing Rule.
    - Annually established rates for discounted care should approximate and not be less than 100 percent (100%) of the Medicare Rate or 100 percent (100%) of the Medicaid base rate, whichever is greater.
    - The Department shall publicly post the established rates on its website: https://hcpf.colorado.gov/hospital-discounted-care
- Collect amounts charged, not including amounts owed by third-party payers, in monthly installments such that the patient is not paying more than four percent (4%) of the patient's monthly household income on a bill from a Health Care Facility.
    - The 4% limit is a maximum. Health Care Facilities are allowed and encouraged to offer patients better payment plans that align with current, new, or updated internal policies.
- Collect amounts charged, not including amounts owed by third-party payers, in monthly installments such that the patient is not paying more than two percent (2%) of the patient's monthly household income on a bill from each Licensed Health Care Professional. This requirement is for Licensed Health Care Professionals that bill separately from the Health Care Facility.
    - The 2% limit is a maximum. Licensed Health Care Professionals are allowed and encouraged to offer patients better payment plans that align with current, new, or updated internal policies.

- Consider the patient's bill paid in full after a cumulative 36 months' worth of payments and cease any and all collection activities on any balance that remains unpaid.

A Health Care Facility shall not:

- Deny discounted care on the basis the patient has not applied for any public benefits program; or
    - 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.

Additional information can be found on the Colorado Department of Health Care Policy and Financing's website: https://hcpf.colorado.gov/hospital-discounted-care

Section 1.02 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. Creditable Coverage means benefits or coverage provided under: (a) Medicare, the "Colorado Medical Assistance Act", Articles 4 to 6 of Title 25.5, C.R.S., or the children's basic health plan established pursuant to Article 8 of Title 25.5, C.R.S.; (b) an employee welfare benefit plan or group health insurance or health benefit plan; (c) an individual health benefit plan; (d) a state health benefits risk pool; or (e) Chapter 55 of Title 10 of the United States Code, a medical care program of the federal Indian health service or of a tribal organization, a health plan offered under Chapter 89 of Title 5, United States Code, a public health plan, or a health benefit plan under Section 5 (e) of the federal "Peace Corps Act", 22 U.S.C. sec. 2504 (e).

C. Elective surgery or elective procedure means a surgery or procedure that is scheduled in advance because it does not involve a medical emergency.

D. 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.

E. Guardian means a parent, legal guardian, or legal representative.

F. Health Care Facility means a hospital that is licensed as a general acute or critical access hospital, a licensed free-standing emergency department, an outpatient health care facility that is licensed as an on-campus department or service of a hospital, and an off-campus health care facility that is under a hospital's license. It does not include Federally Qualified Health Centers or student-learning medical clinics and dental clinics that are established for the purpose of student learning, offering discounted patient care as part of a program of student learning and is physically located within a health sciences school.

G. Health Care Services are defined in the C.R.S. as any services included in or incidental to the furnishing of medical, behavioral, mental health, or substance use disorder; dental or optometric care; hospitalization; or nursing home care to an individual, as well as the furnishing to any person of any other services for the purpose of preventing, alleviating, curing, or healing human physical illness or injury, or behavioral, mental health, or substance use disorder. Health Care Services include the rendering of the services through the use of telehealth, as defined in C.R.S. Section 10-16-123 (4)(e).

H. Household means any person living at the patient's address and any other members who live outside of the state or country that the patient or their guardian provides 50% or more of their support.

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

J. Licensed Health Care Professional mans any health care professional who is registered, certified, or licensed pursuant to Colorado Revised Statutes Title 12, 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.

K. Medically Necessary has the same meaning as defined in CCR 10-2505-10, Section 8.076.1.8.

L. 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 Part 1 of Article 3 of Title 25.5, C.R.S. is not available.

M. 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 assertion of a hospital lien pursuant to C.R.S. Section 38-27-101.

N. Provider means a Health Care Facility or Licensed Health Care Professional.

O. Qualified Patient means an individual whose Household income is not more than 250% of the federal poverty level, and who received a Health Care Service at a Health Care Facility.

P. Screen, Screening, or Screened means a process identified by the Department whereby a Health Care Facility assesses a patient's circumstances related to eligibility criteria, determines whether a patient is likely to qualify for public health care coverage or discounted care, informs the patient of the results of the

screening, and provides information to the patient about how the patient can enroll in public health care coverage.

Q. Uninsured Patient means an individual who does not have Creditable Coverage.

ARTICLE II. PATIENT'S RIGHTS

Section 2.01 Notification of Patient's Rights

The Department of Health Care Policy and Financing has developed a written explanation of a patient's rights under HB 21-1198 that is written in plain language, at a sixth grade reading level and translated into languages spoken by 10 percent (10%) or more of the population in any Colorado county and has published the patient's rights on the Department's website under the Patient Rights section at https://hcpf.colorado.gov/hospital-discounted-care.

At a minimum, Health Care Facilities shall:

- Post the Patient's Rights developed by Colorado Department of Health Care Policy and Financing in all required languages conspicuously on the Health Care Facility's website, including a link to the information on the Health Care Facility's main landing page;
- Make the information available in patient waiting areas;
- Make the information available to each patient, or the patient's legal guardian, verbally, which may include using a professional interpretation service, or in writing the patient's or legal guardian's primary language before the patient is discharged from the Health Care Facility; and
- Inform each patient on the patient's billing statement of the patient's rights 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 primary language. A billing statement includes any patient facing communication, whether electronic or in writing, that specifies an amount due for services and instructions for making payment.

Health Care Facilities shall not:

- Deny discounted care on the basis that the patient has not applied for any public benefits program, or
- 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.

Section 2.02 Presentation of Patient's Rights

The Patient's Rights document created by the Department is available to Providers and patients formatted as a double sided, two-page document. The Department acknowledges that this is not the only format that the information could be presented in. Therefore, Providers are allowed to reformat the Patient's Rights document in a way that they believe is better or easier for their patients. An example of this would be a

brochure format. If a Provider would like to reformat the Patient's Rights, they will need to submit the reformatted document to the Department for approval prior to using their own format.

A reformatted Patient's Rights document may not change or omit any information contained in the Department's published Patient's Rights document. Additionally, a Provider 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.

ARTICLE III. PATIENT ELIGIBILITY REQUIREMENTS

Section 3.01 Self-Attested Screening

Health Care Facilities are required to screen patients using self-attested information to determine if a patient is likely to qualify for hospital discounts and/or public health care coverage. Health Care Facilities are required to offer the screening in the patient's preferred language and use an interpretation service if needed. The Health Care Facility cannot rely on a family member to interpret for the patient unless the patient requests the family member to interpret after being offered a professional interpretation service. As part of the screening process, the Health Care Facility must provide the patient with the Department created "Patient's Rights" document available at https://hcpf.colorado.gov/hospital-discounted-care.

The screening process consists of the patient or their guardian answering the questions on the first page of the Uniform Application in order for the Health Care Facility to determine if the patient likely qualifies for any public health coverage options, or discounted care under the Colorado Indigent Care Program or Hospital Discounted Care, and informing the patient of available financial assistance on the state's health insurance marketplace, Connect for Health Colorado. If the patient's household income is at or below 250% of the federal poverty level, the patient would qualify for Hospital Discounted Care.

A patient has the right to refuse to be screened. In the event a patient refuses to be screened, the Health Care Facility is required to have the patient complete the state approved form to decline screening and keep a copy of the signed form on file. The Decline Screening Form is available on the Hospital Discounted Care website in English and Spanish: https://hcpf.colorado.gov/hospital-discounted-care.

As part of the screening process, a Health Care Facility may ask a patient about household size and household income. However, a Health Care Facility cannot ask a patient about their assets or value of any assets.

See section 4.02 for information on the screening process and requirements.

Section 3.02 Federal Poverty Guidelines (FPG)

Federal Poverty Guidelines is a measure of income level issued annually by the United States Department of Health and Human Services. Federal poverty levels are used to

determine the patient's eligibility for certain programs and benefits. Hospital Discounted Care covers patients up to 250% of FPG. The Department updates the Uniform Application at least once annually on April 1 to update the FPGs to align with Medicaid.

For the purposes of Hospital Discounted Care, the patient's FPG is calculated using gross household income adjusted by their household size, as defined in the following sections. The FPG Calculator is available on the Hospital Discounted Care Rates website under Hospital Discounted Care Maximum Payment Calculator: https://hcpf.colorado.gov/Hospital-Discounted-Care-Rates.

Section 3.03 Household Definition

Any person living in the household can be included on the application for purposes of determining household size. This includes:

- any person living at the patient's address,
- any other members who live outside of the state or country that the patient or their guardian provides 50% or more of their support,
- unborn children for any pregnant household member,
- children age 18 years or older who are attending high school or college and whose parents support them
- children with disabilities, regardless of age, if the patient or their guardian supports the child

Any non-spouse or civil union partner, non-student adults under the age of 65 MUST have financial support attested to in order to be included on the application.

Per Colorado law, the patient or guardian's spouse or civil union partner must be included in the application if they are legally married. This also applies to couples who meet the definition of common law marriage.

Minors should not be rated separately from their parents unless they are emancipated or there exists a special circumstance. Special circumstances include but are not limited to:

- Minors who have a child and obtains medical care for the child.
- Examination and treatment for sexually transmitted diseases, including HIV.
- Examination and treatment for alcohol and/or drug addiction.
- Obstetrical and gynecological procedures, birth control procedures, supplies, or information. If the parents of a minor child who is pregnant have insurance to cover that child, but the insurance excludes pregnancy of the minor and the parents are claiming financial responsibility for the child, that child is not

considered emancipated and should have their determination based on the parents' income.

- Voluntary mental health services, but only if the minor is fifteen years old or older.

- Confidential Teen Services Program - Minors in this program are rated without consideration of their parents' income under the conditions described. Therefore, when minors seek services and claim no income other than the parents' income, they will be charged the nominal or lowest copay offered. If the minor declares personal income, e.g., part-time job, that income will be used in determining their rating.

Health Care Facilities should not include unrelated members of religious orders on the same application. Each unrelated member must complete a separate application.

Section 3.04 Household Income

Household income is defined as follows:

- Employment income from all working non-student adults ages 18 and older
- Self-Employment income from all working non-student adults ages 18 and older
- Except as specified below, unearned income for all household members to include:
    - Supplemental Security Income (SSI)
    - Social Security Disability Insurance (SSDI)
    - Tips, Bonuses, and Commissions
    - Short Term Disability
    - Pension payments
    - Payments from retirement accounts
    - Lottery winnings disbursements
    - Monthly payments from trust funds
    - Unemployment income

- SSI and SSDI payments are not allowed to be counted for minors or adults with disabilities who are still under the care of their parents or guardians.

ARTICLE IV. SCREENING PROCESS

Section 4.01 Screening Timeline

Within 45 calendar days of the patient's date of service or date of discharge, the Health Care Facility must screen each uninsured patient, unless the patient declines, for eligibility for:

- Public health coverage programs including but not limited to Medicare, State medical Assistance Programs (e.g., Health First Colorado), Articles 4, 5 and 6 of Title 25.5, C.R.S. Emergency Medicaid, and Children's Basic Health Plan, Article 8 of Title 25.5, C.R.S.;

- Discounted care through Colorado Indigent Care Program (CICP), established in Part 1 of Article 3 of Title 25.5, C.R.S. if the patient receives a service eligible for reimbursement through the program; and

- Discounted care as described in Section 25-5-3-503, C.R.S.

Since the Health Care Facility has 45 days to complete the screening, hospitals should ensure that patients are in a stable and coherent condition prior to completing the screening or signing the decline screening form prior to being discharged. In some cases, patients are not in a place in which they should be making any decisions until at least 24 hours after they have been discharged. Patients and their guardians, medical power of attorney, or other caregivers should be informed of the patient's right to be screened prior to the patient being discharged, and a screening may be set up at a later date. However, if the circumstances allow, Health Care Facilities are encouraged to screen patients before they leave the facility, especially if it is known that the patient is experiencing homelessness.

If requested by the patient, a Health Care Facility shall screen an insured patient for discounted care. Health Care Facilities have three business days after receiving the insured patient's request to be screened to contact the patient or their guardian to set up the screening. The screening must occur within 45 days of the insured patient requesting the screening.

Section 4.02 Self-Attested Screening

Eligibility technicians must complete the first page of the uniform application using self-attested information for all patients who must be or request to be screened. Providers who have other screening tools that can incorporate all required screening questions may use those tools, but the answers to the questions must be transferred into the uniform application.

From the answers to the questions on the first page of the application, eligibility technicians should determine if all listed household members are considered one or more households under Health First Colorado/CHP+ rules. Once households are determined, an FPG should be calculated for each to determine if the FPGs fall under the limits for the various programs.

If a patient has previously been a Health First Colorado or CHP+ member and they can supply their ID number, it should be checked to see if their coverage is currently active. Supplying their ID number is not a requirement to complete the screening but may negate the need for the screening if their Health First Colorado or CHP+ coverage is active.

If a patient has health insurance, the Health Care Facility and Licensed Health Care Professionals must bill the insurance prior to billing the patient, even if the insurance is out of network. For a patient who believes they are covered under a commercial, private, or other health insurance plan on their date of service, but later discovers they were not covered for the date of service, the Health Care Facility must screen the

patient within 45 days of the date the Health Care Facility is notified that the insurance was not valid for the date of service.

If a patient appears eligible for Health First Colorado and/or CHP+ and opts to apply for those programs and not complete an application for discounted care, but then is found to be ineligible for Health First Colorado and/or CHP+, the patient may request to complete the application for discounted care with the Health Care Facility that provided their services. The patient must be allowed to apply even if they are outside of the usual window to complete the application and within 45 days of the date of the denial.

If the screening determines that the patient likely qualifies for CICP or Hospital Discounted Care and the patient wants to apply, the patient has 45 days to provide the necessary documentation to complete their application. If the Health Care Facility that is completing the screening is not a CICP provider and it appears the patient would qualify for CICP, the Health Care Facility must inform the patient and provide them with information on how to locate a CICP provider. The CICP Provider Directory is available on the CICP Fact Page at https://hcpf.colorado.gov/colorado-indigent-care-program.

If a patient would qualify for CICP or Hospital Discounted Care by applying separately from members they listed within their household (excluding their spouse or civil union partner, whom they must include in their household) the Health Care Facility must inform them and allow them to apply separately from other household members. This does not apply to non-emancipated minors. Patients should be informed that it will almost always be in their best interest to include any minor children under their care as including them will increase their household size and result in a lower FPG.

If a patient appears not to be eligible for CICP or Hospital Discounted Care from the initial screening but wishes to complete the full application to be sure, the Health Care Facility must allow them to apply.

A Health Care Facility is required to inform the patient of the Health Care Facility's results of the screening and, regardless of the result, provide information to the patient about how the patient can enroll in public health care coverage or receive discounted care. For more information about the notice of determination process, see Article 6.

Health Care Facilities shall keep screening forms on file until June 30 of the seventh state fiscal year after the patient's date of service or date of discharge, whichever is later.

Section 4.03 Decline Screening Policy and Form

Patients may decline the screening for public health care coverage and/or discounted health care. The decision to decline screening is not final.

If an uninsured patient declines to be screened, the patient may still request to be screened and apply for discounts using the uniform application within 30 days of the billing date. Providers cannot send additional bills to the patient after the request for

screening has been made until the screening has been completed and the patient has been provided with the notice of determination and the opportunity to appeal.

If a patient declines the screening, the Health Care Facility shall document the patient's decision using the decline screening form. Health Care Facilities shall keep the signed decline screening form on file until June 30 of the seventh state fiscal year after the patient's date of service or date of discharge, whichever is later.

Generally, a decline screening form only covers one episode of care and any services provided related to the original episode of care. A decline screening form may cover additional past dates of service if the patient or their guardian signs a decline screening form that notes those specific past dates of service or a past date range that includes those specific past dates of service. A decline screening form cannot be collected for dates of service that have not occurred yet and are not related to a previous episode of care.

A patient's decision to decline the screening that is documented and complies with Colorado Department of Health Care Policy and Financing CCR Rule is a complete defense to a claim brought by a patient under CSR Section 25.5-3-506 (2) for a violation of CSR Section 25.5-3-506 (1)(a) OR (1)(b).

Section 4.04 Screening Best Efforts

For patients who were discharged or who otherwise leave the facility 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 which should be the method that the patient indicates is their preferred method of contact. These methods can include phone calls, SMS messages, emails, and portal messages. Contact attempts should be made at least once a month for six months after the patient's date of service or date of discharge, whichever is later, with the first contact sent prior to the 46th day past the patient's date of service or date of discharge, whichever is later. Bills may be sent beginning 46 days after the patient's date of service or date of discharge, whichever is later. Documentation of these communication attempts with the patient that are kept in the patient's record will meet the screening requirements for Health Care Facilities.

If the patient requests that the Health Care Facility cease contacting them related to completing the screening, the Health Care Facility may consider the patient screening requirements fulfilled. The Health Care Facility must document the patient's request and maintain the request as part of the patient's record.

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 Health Care Facility may consider it an informed decision to decline screening. Outreach attempts must alert the patient that the failure to respond may result in the loss of their right to be screened for cost saving options. Outreach attempts must be documented within the patient's file and, at a minimum, must include:

- calling any phone numbers provided by the patient and leaving voice messages with allowable information under the Health Insurance Portability and Accountability Act and the Telephone Consumer Protection Act if the calls are unanswered,
- sending 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,
- sending emails to any email address provided by the patient, and
- sending messages through any appropriate patient portal.

Section 4.05 Accounts of Deceased Patients

In the event that a patient passes away prior to being screened, the Health Care Facility shall present the Patient's Rights document to the patient's spouse, guardian, power of attorney, or executor of the patient's account. A family member or other representative may complete the screening and determination process on behalf of the deceased patient. The person completing the screening and determination process is not responsible for the patient's bills.

ARTICLE V. APPLICATION PROCESS

Section 5.01 Uniform Eligibility Application

Health Care Facilities shall use a single uniform application developed by the Department to determine eligibility for CICP and Hospital Discounted Care. Applications for discounted care can be completed before or after care is received at the Health Care Facility.

Patients who complete the self-attested screening process with the Health Care Facility and appear eligible for Hospital Discounted Care or the CICP and want to apply, or patients who appear ineligible but who still wish to complete the application to find out for sure have 45 days from the date of the screening to submit all required documentation to the Health Care Facility. If the patient does not submit all the required documentation within the 45-day time period, they may need to resubmit updated documentation that reflects their current income in order for the Health Care Facility to accurately calculate their current household income.

A Health Care Facility shall provide the patient notice of the determination and an opportunity for the patient to appeal the determination in accordance with CCR (25.5-3-502 (3)).

Section 5.02 Acceptable Documentation for the Uniform Application

A Health Care Facility may request the following information and documents to establish current financial income eligibility for discounted health care based on the most recent month's income:

- First and last name, address, contact information (e.g., email, phone), and birth date for the applicant and any other household members included in the application
- Employer and income information for each working adult household member
    - For employed household members, excluding those who work exclusively jobs for cash, either
        - Paycheck stubs, payroll history, or other wage records, or
        - A letter from their employer stating their salary or hourly wage and usual number of hours worked per pay period, or
        - Most recent tax return, or
        - The eligibility technician may contact the employer to get verbal confirmation of their pay. Documentation of who was contacted, their contact information, and the pay information they supplied must be kept within the patient's application.
    - For self-employed household members, either
        - Paycheck stubs, payroll history, or other wage records if they pay themselves as an employee of the business,
        - Business financial records, including but not limited to profit and loss statements, ledgers, business bank accounts showing deposits and withdrawals, invoices and receipts, etc. (Patients do not need to provide all of these documents, just enough to show their monthly income), or
        - Most recent tax return, if the household member does not have an available record of more recent business income and expense activity.
    - Household members who work jobs for cash must provide
        - Bank receipts showing cash deposits made, or
        - Ledgers (account book, list of income and expenses, etc.) or other documentation of payments from clients, or
        - Letters from their employer (i.e. stating how much they normally pay them for their services in a month).
- For household members receiving unemployment benefits, their unemployment compensation documentation
- For household members receiving Short Term Disability, their Short Term Disability payment information
- For adult household members with no income, a letter attesting they have no income.

When calculating income, the Health Care Facility shall obtain the minimum amount of documentation to substantiate amounts.

Patients who are experiencing homelessness are exempt from the documentation requirements and are allowed to use self-attested information for both the screening and the application for discounted care.

Section 5.03 Methodology to Determine Patient Income

The Department categorizes income into three categories. These categories are:

- Employment Income
- Unearned Income, and
- Self-Employment

When calculating income, the Health Care Facility shall obtain the minimum amount of documentation to substantiate amounts.

Employment income is income earned (including overtime, bonuses, tips, and commissions) for providing services to another individual or company. Earned income from a working minor (under the age of 18) or an adult student living with their parents or guardians is exempt. Employment income for Hospital Discounted Care does not include self-employment income which is addressed separately. See Section 5.02 for documentation requirements.

For household members who receive pay stubs, questions related to the household members pay stub that the household member cannot answer, including but not limited to their pay period, how many paychecks they have received for the year, etc., should be verified by the applicant's employer either in writing or over the phone. Health Care Facilities should record the name of the enrollment staff that called, who they spoke to, what the position is of that person (manager, HR, etc.), and the time and date of the phone call in the notes section of the application.

There are three steps to calculating current employment income. The following instructions are geared toward the paper version of the application, as the calculations will be completed automatically in the Excel version of the application when amounts are entered into the appropriate spaces.

Step 1. Obtain documentation for most recent months' employment income. The determination process looks at the financial circumstances of a household as of the date an application is started. If an applicant has just started a new job, for example, and has less than one month's worth of pay stubs, or has not received a paycheck yet, providers may use one of the other verification methods specified in Section 5.02 to collect information to calculate the applicant's monthly income and convert to an annual income. The Department recommends calculating the monthly income using the Year-to-Date Method as described below. Complete Worksheet 1 – "Earned and Unearned Income" using gross amounts. "Gross" means the dollar amount before any deductions or losses are subtracted.

Step 2. Use one of the following methods to determine the monthly gross employment income. Write the total amount of gross employment income in the monthly total column on Line 1, Section II of the application.

Year-to-Date Method:

The Year-to-Date Method of calculating annual gross income uses the applicant's year-to-date gross earnings on the most current year-to-date pay stub. For this method, only one pay stub would be needed. To determine the annualized income, count the number of paychecks that have occurred since January 1, and then divide that number into the gross year-to-date earnings stated on the pay stub. The result of this calculation is then multiplied by the number of pay periods in a year to determine the annualized gross earnings. If the applicant has not been at their job since January 1 but it can be determined how many paychecks they have received for the year, this method can still be used.

Example: The applicant provides a recent pay stub showing year-to-date earnings of $13,756. The pay frequency is bi-weekly. The pay period ended September 30th and since January 1st the applicant has been paid 19 times. The calculation would be as follows:

Divide $13,756 by 19 bi-weekly pay periods = $724.00

Multiply $724 by 26 bi-weekly pay periods in a year = $18,824

Average Pay Method:

The Average Pay method of calculating income uses the average gross earnings based upon the number of pay stubs provided. When using this method, the Department recommends that the provider obtain at least a full month of pay stubs from the applicant. To determine the average gross earnings, total all the gross earnings of all the pay stubs provided and divide the result by the number of pay stubs. The result will be the average gross earnings per pay period. Next, determine if the applicant is paid weekly, bi-weekly, or semi-monthly. Convert the average gross earnings to monthly income.

Unless the applicant is paid semi-monthly DO NOT add up all the paychecks for the month and multiply by 12 to calculate the applicant's annual income. This will either understate or overstate the applicant's income depending on the pay frequency and month. To calculate monthly income properly, use the following conversions:

1. To convert weekly income to monthly income, multiply by 4.333
2. To convert bi-weekly (every two weeks) income to monthly income, multiply by 2.1666
3. To convert semi-monthly (twice a month) income to monthly income, multiply by 2

Lastly, annualize the average monthly gross earnings by multiplying by 12.

Example: An applicant provides six pay stubs with gross earnings of $534.00, $475.00, $398.00, $534.00, $498.00 and $534.00. The pay frequency is weekly. The calculation would be as follows:

Add: $534.00, $475.00, $398.00, $534.00, $498.00, and $534.00 = $2,973.00

Divide: $2,973.00 by 6 pay stubs = $495.50 average weekly gross earnings

Multiply: $495.50 by 4.333 = $2,147.00

Multiply: $2147.00 by 12 months = $25,764.00

Example: The applicant is paid every two weeks and has received only one paycheck. The calculation would be as follows:

Monthly gross earnings = $200 x 2.1666 = $433.32 per month

Annual income = $433.32 x 12 months = $5,199.84 per year

Example: If the applicant has just started a job but has not received a paycheck yet, a letter from the applicant's employer is allowable. Use the information in the letter to calculate the monthly income using the Average Pay Method. The calculation would be as follows:

Letter from the employer with hourly wage and hours to be worked per week:

Weekly earnings = $15.00 per hour x 20 hours per week = $300 per week

Monthly gross earnings = $300 x 4.333 = $1,299.90 per month

Annual income = $1,299.90 x 12 months = $15,598.80 per year

Monthly Pay Method:

Note that this method is only accurate for applicants with fixed salaries. Employees paid monthly on an hourly basis will likely have paychecks that vary in amount month to month. The monthly pay method of calculating income utilizes the most recent monthly pay stub. Use the monthly income and annualize.

Step 3. Write the annualized total income from Step 2 on Line 1 in the "Annualized Total" column of the application.

Section 5.04 Additional Deductions

Providers may make additional deductions to a patient's household income determination based on existing, new, or updated policies at their facilities. The Department recognizes that Providers are well versed in the needs of their individual communities, and that what one Provider considers an important deduction for their patients may not make sense for another Provider. Deductions can be included in the Uniform Application on Worksheet 3.

Section 5.05 Determination and Redetermination

A determination is not considered to be complete until all required documentation has been provided by the patient or guardian and the Health Care Facility has calculated their household FPG. The Health Care Facility must calculate the household FPG and inform the patient of the determination within 14 days of receipt of all required documentation. Health Care Facilities are responsible for informing all associated

Licensed Health Care Professionals of the patient's determination outcome, as well as any appeals made by the patient challenging the Health Care Facility's determination. A patient may also provide notice of their discounted care determination to the Licensed Health Care Professional and, whether the Licensed Health Care Professional received the notice from the Health Care Facility or from the patient, the Licensed Health Care Professional must accept the determination notice as conclusive evidence of the patient's eligibility for discounted care.

The determination is valid for one year from the date of the application, which should match the date the application was started, or the first date of service the application is being completed to cover, whichever is earliest.

Health Care Facilities must complete a redetermination for any patient or guardian who requests one at any point during the patient's established payment plan or if they receive additional unrelated services. A Provider may not increase a patient's established payment plan amount if their redetermination results in a higher FPG. If a patient's redetermination results in a lower FPG, a Provider must lower the monthly payments in order to comply with the 4% facility limit and 2% per professional limit and may not add months to a patient's established payment plan.

ARTICLE VI. NOTICE OF DETERMINATION

Section 6.01 Process for Determination Notice

A Health Care Facility shall determine the patient's eligibility for the CICP and/or Hospital Discounted Care and send the determination notice within 14 days of all required documentation being provided by the patient or their guardian. The Health Care Facility shall send the patient a letter in the patient or guardian's preferred language explaining the determination.

- For patients determined to be eligible for discounted care, the determination notice must include but is not limited to:
    - The programs and discounts for which the patient was determined likely eligible for, including but not limited to Medicaid, Emergency Medicaid, CHP+, Medicare, 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 likely or potentially eligible for.
        - If the patient appears likely or potentially eligible for a program and there is a deadline by which the patient must apply for that program in order for their services to be covered, that date must be included in the determination notice.
    - The dates for which the discounted care determination is valid.
    - The household size and income used to determine eligibility and the household calculated FPG.

    - The patient's 4% and 2% limits based on their calculated gross household income.
    - If the patient was applying and approved for CICP, the patient's CICP rating.
    - If the patient was applying and approved for CICP, the patient's CICP copay cap.
    - If the Health Care Facility is not a CICP provider, information on where the patient may obtain CICP services.
    - Information on how to file a complaint and how to file an appeal with the Health Care Facility and the Department, including but not limited to the contact information of the person at the Facility who handles appeals and the Department's Hospital Discounted Care email (hcpf_HospDiscountCare@state.co.us).
- For patients determined not eligible for discounted care, the determination notice must include but is not limited to:
    - The basis for denial of discounted care.
    - The programs and discounts for which the patient was determined likely eligible for, including but not limited to Medicaid, Emergency Medicaid, CHP+, Medicare, 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 likely or potentially eligible for.
        - If the patient appears likely or potentially eligible for a program and there is a deadline by which the patient must apply for that program in order for their services to be covered, that date must be included in the determination notice.
    - The service date or dates the discounted care denial covers and an explanation that the household may qualify for coverage of future services if there is a change in household size or income.
    - The household size and income used to determine eligibility and the household calculated FPG.
    - Information on how to file a complaint and how to file an appeal with the Health Care Facility and the Department, including but not limited to the contact information of the person at the Facility who handles appeals and the Department's Hospital Discounted Care email (hcpf_HospDiscountCare@state.co.us).

Patients have 30 days from the date on the notice to file an appeal. Health Care Facilities may accept appeals filed after the 30-day window has passed if there exists a good cause as to why the appeal was not filed timely. If a Health Care Facility denies an appeal that was filed after the 30-day window, the facility must inform the patient that they have the right to appeal to the Department and provide the patient with the Department's contact information. The Department has final say on if the patient's untimely filing was due to a good cause.

The written notice of determination should be sent to the patient or their guardian through the patient's preferred method of communication.

Section 6.02 Notification of Licensed Health Care Professionals

It is the responsibility of the Health Care Facility to inform any Licensed Health Care Professionals of the patient's determination so that they may begin the process of contacting the patient to set up their payment plan. This notification should be made at the same time the patient is notified. Alternatively, the Health Care Facility is allowed to set up a process with the Licensed Health Care Professionals who work within their facility to send weekly or bi-weekly reports of patients who have been screened, patients who have completed the application process, and the determinations for those patients.

Health Care Facilities must ensure that any additional Licensed Health Care Professionals are notified of the patient's eligibility for discounted care if the patient seeks additional services during the time period their determination is valid.

Section 6.03 Determination Card for Patients

Included in the Excel version of the Uniform Application is a tab containing a template for a card that can be issued to patients showing their FPG determination, whether they were approved for Discounted Care, the CICP, or both, their 4% and 2% monthly maximum payment amounts, and their CICP copays and copayment cap, if applicable. Providers are welcome to use this template if they wish to issue cards to patients to make it easier for the Provider when the patient is seen again during their eligibility period. Providers are also welcome to create their own cards. If a Provider opts to create their own cards, the cards must at a minimum include the patient's eligibility for Discounted Care and/or the CICP, the patient's calculated FPG, the effective dates of the determination, the household 4% and 2% limits, and the CICP copays and copay cap for the household if applicable. The cards can also include the patient's eligibility for the Provider's own internal charity care program so that one card may be used for all patients who receive an eligibility determination from the Health Care Facility. Issuing cards to patients who are determined eligible for Discounted Care is not mandatory but may be helpful for both the Provider and the patient.

Section 6.04 Determination Portability

Providers are allowed and encouraged to accept determinations from other facilities. If a provider accepts another facility's determination, a copy of the patient's determination notice or card must be included in the patient's record for auditing purposes.

Providers are allowed to include deductions to patient household income based on their internal policies, and therefore a patient's determination may vary from facility to facility. Providers that accept another facility's determination are allowed to accept either a card or a determination notice from the patient or the facility that made the original determination. Additionally, the Provider may contact a facility that has previously made an eligibility determination for a patient to request the patient's

application and supporting documentation with the permission of the patient. Providers would be able to use the patient's previous application to complete their own determination for the patient that includes different deductions depending on the provider's deduction policies.

ARTICLE VII. BILLING

Section 7.01 Timing of Patient Bills

Health Care Facilities and Licensed Health Care Professionals should refrain from sending patients bills until after the patient has been screened or signed a decline screening form. Bills must not be sent to patients prior to the 46th day past their date of service or date of discharge, whichever is later, and may not be sent during the time period the patient is waiting to be screened or is actively completing the discounted care application. The billing departments for the Health Care Facility and Licensed Health Care Professional may send the patient's first bill after a patient has been screened and opted not to complete an application, after the application has been completed and the patient has been notified of the determination, or after a signed decline screening form has been obtained or the patient has otherwise informed the Health Care Facility that they do not wish to be screened during the Health Care Facility's completion of the Patient Contact Best Efforts.

In the event that the patient has not been screened, has not set up a screening appointment, and has not signed a decline screening form, the provider may begin sending bills beginning 46 days after the patient's date of service or date of discharge, whichever is later.

Section 7.02 Charge Amounts versus Billed Amounts

Health Care Facilities and Licensed Health Care Professionals must bill patients according to the rates set by the Department but are allowed to continue using their normal charges in write off amounts for reporting purposes. This applies to both reporting under Hospital Discounted Care and for other charity care purposes.

The allowable billed amounts may be higher than what a patient may pay on the payment plans determined by their household income. Providers are allowed to include the difference in the lower of the allowable billed amount and the patient's established payment plan in their write off amounts as well.

Section 7.03 Related Charges

For the purposes of billing and setting up payment plans, the Department considers all services provided to a patient that are related to the same event to fall under one service episode. This means that the patient would only need to be screened once for all the related services and their payment plan would apply to all of the bills for the related services.

For example, if a patient had a heart attack and went to the emergency room and was scheduled for a follow up visit the next week to monitor how they were recovering, both the emergency room visit and the follow up visit would be considered one episode of care and would fall under the same payment plan. If the patient had a second heart attack a few months later, that would be considered a separate episode and would fall under a new screening, billing, and payment plan.

Section 7.04 Third Party Payments

Health Care Facilities and Licensed Health Care Professionals must bill an insured patient's health insurance prior to sending a bill showing the patient's portion of the bill. If an insured patient has not yet been screened, they have 45 days from the date of the bill after the insurance adjustment to request to be screened. Health Care Facilities have three business days to respond to the request and set up a screening appointment.

If an insured patient is determined eligible for discounted care, the allowable billed amount would be the lesser of the remainder of their bill after the insurance adjustment, their copay and/or deductible, or the rate set by the Department. Payment plans for insured patients who qualify for discounted care must follow the 4%/2% limits.

ARTICLE VIII. PAYMENT PLANS

Section 8.01 General Rules for Payment Plans

Health Care Facilities and Licensed Health Care Professionals must allow for qualified patients to set up payment plans for their medical bills under Hospital Discounted Care. Patients are not allowed to be sent to outside institutions to obtain loans to pay off their medical bills 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.

Payment plans for bills for qualified patients must not exceed 4% of their monthly household income on bills from Health Care Facilities and must not exceed 2% of their monthly household income on bills from each Licensed Health Care Professional who bills separately from the Health Care Facility. Payment plans may be established for less than the 4%/2% limits.

Payment plans may not exceed 36 months but may be made for a lesser amount of time, provided the monthly payments do not exceed the 4%/2% limits described above.

The 4%/2% limits are maximums. If a Provider wants to allow a patient to have a more generous payment plan, or if a Provider has current, new, or updated policies that set lower limits for patient payment plans, those are allowable and encouraged for Hospital Discounted Care. Providers must not create any payment plans that are longer than 36 months of payments, however providers may be flexible in allowing patients to skip

months and add those payments to the end of the payment plan, resulting in a longer payment plan but retaining a maximum of 36 payments.

Section 8.02 Payment Plan Structure

Providers should contact patients by the patient's indicated preferred method of contact within 30 days of their determination to settle their bill or set up their payment plans unless the patient has submitted an appeal of their determination. Patients have no less than 181 days past their date of service or date of discharge, whichever is later, to make a payment. If a patient wishes to pay off their bill all at once and not set up a payment plan, the highest amount that they would be required to pay is the same amount as if they set up a 36-month payment plan at 4% of their monthly income for the facility bill or 2% of their monthly income for each professional bill or the allowed bill amount, whichever is lower.

It is possible that the allowable billed amount is less than what a 36-month payment plan would be for a patient. In this case, the payment plan can be adjusted either for less money per month and last the full 36 months or it can be set up utilizing the 4% limit for fewer than 36 months.

Once a payment plan has been established, a Provider may not require a patient to complete a redetermination related to services the payment plan covers. A patient may request to be redetermined if they have experienced a change in household size or income. If the redetermination results in a higher FPG, the monthly amount may be adjusted but the total amount due cannot be changed. If the redetermination results in a lower FPG, the monthly amount must be reduced to adhere to the 4%/2% limits but the length of the payment plan may not be adjusted.

Section 8.03 Pre-Payment or Upfront "Paid in Full" Options

Health Care Facilities and Licensed Health Care Professionals are allowed to offer a discount bill amount if the patient pays in full upfront, but this lower amount must not exceed the allowable billed amount or the amount the patient would be responsible for in the 36-month payment plan, whichever is lower. For example, if the patient's application determines that their 4% monthly payment amount would be $100, the Health Care Facility would be allowed to offer them a "paid in full discount price" of no more than $3,600. However, if the allowable billed amount for their services is $3,200, the "paid in full discount price" would be set to no more than $3,200.

Section 8.04 Completion of Payment Plan

A patient's payment plan is considered complete after they have made 36 months' worth of payments or paid the full amount for which they were billed, whichever occurs sooner. A patient is allowed to pay extra towards their payment plan in order to shorten its length.

Once the patient has completed their payment plan, the Health Care Facility or Licensed Health Care Professional must consider their balance paid in full for the associated bills and cease any and all collection efforts on the remaining balance.

Section 8.05 Payment Plan Examples

Payment plans may be created for patients at a maximum of 4% of the gross monthly household income for bills from Health Care Facilities and a maximum of 2% of the gross monthly household income for bills from each Licensed Health Care Professionals who bill separately from the facility. These are maximums and Providers are allowed and encouraged to grant payment plans to patients that are more favorable. The following is an example of various payment plans that can be set for a patient that would fall under the guidelines of Hospital Discounted Care.

Example: A household is seen at a facility for injuries stemming from a car accident. The household consists of four members, two parents and their minor children. Both parents sustain injuries that require surgery to fix broken bones and internal injuries. The household is screened and completes a discounted care application that results in a household FPG of 205.

Payment Plan Option #1: The family sets up a payment plan that follows the maximum Hospital Discounted Care guidelines: $189 for 36 months for each parent, resulting in a combined payment plan of $378 for 36 months and a total of $13,608.

Payment Plan Option #2: During the conversation of setting up a payment plan, the family indicates that there is no way that they would be able to afford a monthly payment of more than $250. Their payment plan is set at their indicated $250 maximum for 36 months, resulting in a total payment plan of $9,000. The facility then includes the difference between the maximum payment plan and the agreed to payment plan ($4,608) in their annual write off data that is submitted to the Department.

Payment Plan Option #3: The facility has existing policies that state that payment plans are capped at 6% of the household's gross monthly income. Using that policy, the facility sets the family's payment plan at $284 for 36 months, for a total payment plan of $10,224. The facility can include the difference between the maximum payment plan and agreed to payment plan ($3,384) in their annual write off data that is submitted to the Department.

ARTICLE IX. COLLECTION ACTION

Section 9.01 Collections Process under Hospital Discounted Care

Before assigning or selling patient debt to a collection agency or debt buyer, or before pursuing any permissible extraordinary collection action, a Health Care Facility or Licensed Health Care Professional must:

- Screen any uninsured patient and any insured patient who requests screening for eligibility for public health coverage and discounted care as defined in Section 4.01;
- Discount the charges for any patient who has been determined eligible for CICP or Hospital Discounted Care;
- Provide in the patient's primary language a plain language explanation of the services and charges being billed and notify the patient of potential collection actions; and
- Bill any third-party payer that is responsible for providing health care coverage to the patient, regardless of whether the health insurance is in- or out-of-network.

The letter explaining the services and billed amounts and notification of potential collections actions must be sent to the patient or guardian at least 30 days prior to collections actions being started.

Beginning June 1, 2022, no Health Care Facility or Licensed Health Care Professional or their billing offices collecting on a debt for hospital services shall engage in any permissible extraordinary collection actions until 182 days after the date of service or date of discharge, whichever is later.

Section 9.02 Collections Amounts Allowable

Billed amounts pursued by a Health Care Facility and a Licensed Health Care Professional through any collections process may not exceed the applicable discounted care rate established by the Department minus any payments received from the patient or a third-party payer. Health Care Facilities and Licensed Health Care Professionals are not allowed to send qualified patients to collections seeking the full amount of their care.

Section 9.03 Collection Timeline for Patients with Established Payment Plans

Collections actions are not allowed to be started for any patient with an established payment plan until after the third consecutive month of missed payments, or 182 days from the date of discharge, whichever is later. After the second missed payment but not prior to 152 days after the date of discharge, the Health Care Facility must send written notification that potential collections actions may be started if the third payment is missed to the patient by the patient's indicated preferred method of contact. If the patient has indicated that their preferred method of contact is by phone, the facility must also send either a follow up letter or email to the patient so that the facility has written documentation that they contacted the patient. The notification must include an opportunity for the patient to report a change in their household size or income that would lower their monthly payment limits. If a change has occurred, the Health Care Facility must offer to complete a new application with the patient and adjust their remaining payments accordingly. If the missed payments are on a Licensed Health Care Professional bill, the Licensed Health Care Professional must inform the Health Care

Facility of any patient report of changed household size or income so the Health Care Facility may begin the redetermination process.

For example, if the patient's original application calculated 4% of the patient's monthly income to be $100 but after having their income recalculated it is determined that 4% of their gross monthly income is now $80, their payment plan must be amended to $80 for the remaining term of their 36-month plan. Health Care Facilities and Licensed Health Care Professionals are not permitted to adjust the length of the payment plan to account for lower monthly payments.

ARTICLE X. REPORTING REQUIREMENTS

Section 10.01 Health Care Facility Reporting

Beginning in June 2023, Health Care Facilities are required to report to the Department regarding Hospital Discounted Care. The data is required to be disaggregated by race, ethnicity, age, and primary language spoken.

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 being taken to improve data collection and the date by which the facility will be able to disaggregate the required data.

Health Care Facilities will be expected to report on the number of screenings completed, the number of decline screening forms signed, and the number of applications processed.

On the billing side, Health Care Facilities will be expected to report the number of payment plans created, the number of payment plans completed, the number of accounts sent to collections and how many of those were from patients who declined screening or didn't complete the application process versus those who defaulted on established payment plans.

Additionally, Health Care Facilities must report the following information for qualified patients:

- Various patient groups that includes race, ethnicity, age, primary language spoken, and insurance status for the following areas
    - Received eligibility screening
        - Total eligibility screenings
        - Unique patients receiving an eligibility screening
    - Number of days to complete the eligibility screening
    - Declined eligibility screening
        - Total declined eligibility screenings
        - Unique patients declining an eligibility screening
    - Unique uninsured patients who were not screened and did not formally decline screening

    - Reason for eligibility denial
    - Completed a discounted care application
        - Total discounted care applications completed
        - Unique patients completing a discounted care application
    - Received discounted care and the program
    - Eligibility denied for discounted care
    - Reason for discounted care eligibility denial
    - Number of visits for patients under discounted care
    - Number of admissions for patients under discounted care
    - Number of days for patients under discounted care
    - Received a payment plan
    - Total number of payment plans created
    - Paid the payment plan in full prior to the cumulative thirty-six months of payments or payment plan paid in full due to cumulative thirty-six months of payments reached
    - Sent to collections and for what physician/service
    - Number of total accounts sent to collections
    - Minimum, Maximum, and Median of the account balances sent to collections
- Collection practices
- Charges, Billed Amounts, and Write off Charges
    - Total Provider Charges
    - Allowable Billed Amounts
    - Third Party Payments
    - Total Payment Amount due from Patients with Established Payment Plans
    - Write off Charges (Difference between Total Charges, Third Party Payments, and Established Payment Plans)
- Number of Physicians or Physician Groups that bill separately from the Health Care Facility
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ARTICLE XI. APPEALS

Section 11.01 Appeals Process for Ineligible Determinations

If a patient is determined ineligible after the Hospital Discounted Care application is completed, the patient has the right to appeal the decision. Health Care Facilities must inform the patient in their determination notice that they have the right to appeal their determination. For a patient to appeal a Health Care Facility's eligibility decision, the following process must be followed:

1. The patient has 30 calendar days from the date on the determination letter to appeal the Health Care Facility's eligibility determination. This must be done in writing via mail, email, or patient portal message if available to the Health Care Facility that made the determination.

2. The Health Care Facility must confirm receipt of the appeal letter within three business days and has 15 calendar days from the date of the patient's appeal to complete a redetermination of eligibility and respond to the patient and the Department.
3. If the Health Care Facility upholds its initial eligibility determination, the patient can proceed to the next step of the appeals process. If the Health Care Facility finds that the initial eligibility determination was inaccurate, they must correct the application and issue the patient a determination notice following the requirements outlined in Section 6.01.
4. The patient has 15 calendar days from the date of the Health Care Facility's initial appeal decision to contact the Department in writing. This appeal can be submitted to hcpf_hospdiscountcare@state.co.us with a subject line of, "Appeal of Discounted Care Redetermination" and the patient's name, or a letter can be sent to:

   Department of Health Care Policy and Financing
   Attention: Hospital Discounted Care
   % State Programs Unit, Special Financing Division
   1570 Grant Street Denver, CO 80203
5. The Department has 15 calendar days from the email date or date of receipt of the letter to review the documentation and make a final determination. A final determination letter will be sent 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 they are eligible for discounted care for the care received in the Health Care Facility for that specific date or date span. The redetermination letter must meet the notice requirements outlined in Section 6.01.

Section 11.02 Appeals for Determination Based on Incorrect Information

A patient has the right to appeal a determination due to incorrect information being used by the Health Care Facility that resulted in a higher determination and payment plan than the patient would have received if the correct information was used. The patient or guardian should use the same process as outlined in Section 11.01 above to appeal a determination using incorrect information.

If a determination was made based on information that was incorrectly provided by the patient due to the patient misunderstanding what was needed from them, the provider must complete a redetermination with the corrected information provided by the patient. This includes both ineligible determinations and determinations that resulted in a higher determination and payment than if the patient had submitted the correct information.

Section 11.03 Appeals for Non-Receipt of Determination Notice

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.

Section 11.04 Department Monitoring of Appeals

The Department will keep records of all appeals and their final determinations for each Health Care Facility. If the Department determines a Health Care Facility has a repeated pattern of errors in patient eligibility determination, 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.

ARTICLE XII. COMPLAINTS

Section 12.01 Complaint Process

If a patient feels that their rights under Hospital Discounted Care have been violated, they can file a complaint against the Provider for noncompliance.

Patients and their guardians may file complaints against Providers directly with the Department. Patients do not need to file a complaint with the Provider prior to filing a complaint with the Department. Complaints sent to the Department can be submitted by email to the hcpf_HospDiscountCare@state.co.us inbox, by phone at 303-866-2580, or by mail addressed as follows:

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

The Department will conduct a review within 30 days after receiving the complaint.

Section 12.02 Department Monitoring of Complaints

The Department will keep 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 and/or training. Providers will have 90 days to submit a corrective action plan. Extensions may be given up to 120 days at the Department's discretion.

ARTICLE XIII. COMPLIANCE AND CORRECTIVE ACTION

Section 13.01 Audits

The Department will periodically audit Providers to ensure compliance with the rules and policies related to Hospital Discounted Care. If the Department finds that a Provider is not in compliance with the Hospital Discounted Care rules or policies set forth in this

manual, the Department will notify the Provider. The Provider will have 90 days from the date of the Department notification to complete and submit a corrective action plan addressing any and all compliance issues identified by the Department. The corrective action plan must include measures that will be or have been taken to inform patients about the noncompliance and provide any necessary financial corrections for impacted patients.

A Provider may request an extension of their corrective action plan up to 120 days which the Department will grant at its discretion. The Department may require any Provider who is not in compliance with the rules or policies to develop and operate under a corrective action plan until the Department determines that the Provider is in compliance.

Section 13.02 Fines

If the Department determines that a Provider's noncompliance with the rules or policies for Hospital Discounted Care is knowing or willful, or if there is a repeated pattern of noncompliance, the Department may fine the Provider up to $5,000. If the Provider fails to take corrective action or file a corrective action plan with the Department, the Provider may be fined up to $5,000 per week until the Provider takes corrective action.

The Department will take into account the size of the Provider and the seriousness of the noncompliance issue when setting the fine amount.

ARTICLE XIV. RATES

Section 14.01 Rate Setting

Rates for Hospital Discounted Care are set annually by the Department. Rates are determined by comparing the Medicare and Medicaid Base Rates and selecting the higher of the two. New rates will be published annually on July 1 using the most recent Medicare information as of April 1 each year. Rates can be found on the Department's Provider Rates and Fee Schedule page located at https://hcpf.colorado.gov/provider-rates-fee-schedule.

Section 14.02 Inpatient Service Rates

Inpatient Service Rates are used when a patient has health care provided in a hospital and is discharged after 24 hours. Inpatient Service Rates are determined by comparing the Medicare and Medicaid rates for each hospital and selecting the greater of the two.

Inpatient Service Rates are subject to eligibility and billing maximums. Inpatient Service Rates files available on the Department's website include the following:

- Medicare Provider CCN - The "CCN" is a unique hospital facility identifier assigned by the Centers for Medicare & Medicaid Services.
- Hospital Name - The "Hospital Name" is the name of the hospital.

- Rate - The "Rate" is the maximum amount a patient can be charged for inpatient services. This rate is separate from the maximum total amount a patient is responsible for under Hospital Discounted Care.

Section 14.03 Outpatient Service Rates

Outpatient Service Rates are used when a patient has health care provided in a general acute care, critical access hospital or a free-standing emergency department and is discharged within a 24-hour period. Outpatient Service Rates are determined by comparing the Medicare rate and Medicaid base rate and selecting the greater of the two.

Outpatient Service Rates are subject to eligibility and billing maximums. Outpatient Service Rates files available on the Department's website include the following:

- Procedure Code - A collection of codes that represent procedures and services which may be provided to Medicaid and Medicaid beneficiaries.
- Code Description - The "Code Description" is a shortened explanation of the procedures or services the procedure code is associated with.
- Rate - The "Rate" is the maximum amount a patient can be charged for the associated procedure or service.

Section 14.04 Professional Service Rates

Professional Service Rates are used when a patient receives services from a certified health care professional during a hospital visit. Professional Service Rates do not vary by hospital and are the same statewide. Professional Service Rates are determined by comparing the Medicare rate and the Medicaid base rate and selecting the greater of the two.

Professional Service Rates are subject to eligibility and billing maximums. Professional Service Rates files available on the Department's website include the following:

- Procedure Code - A collection of codes that represent procedures and services which may be provided to Medicare and Medicaid members.
- Code Description - The "Code Description" is a shortened explanation of the procedures of services the HCPCS is associated with.
- Rate - The "Rate" is the maximum amount a patient can be charged for the procedure or service.