CICP Policies and Procedures

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COLORADO
Department of Health Care Policy & Financing

Objectives

- Policies and Procedures
- What has changed with Hospital Discounted Care
- Timeline for changes

Provider Responsibilities

Providers participating in the CICP shall:

1. Treat all clients with respect and with consideration for the client's dignity and privacy;
2. Inform clients of how to express opinions, compliments or concerns, and how to make a complaint without fear of reprisal;
3. Strive to provide timely resolutions to the client's complaints or concerns;
4. Protect the privacy and confidentiality of the client's health and financial records;
5. Offer clients information on all treatment options, and allow clients to participate in decisions regarding his or her health care;

Provider Responsibilities (cont.)

6. Notify the client of the availability of sign language and interpreter services in accordance with applicable laws and regulations, when such services are necessary;
7. Ensure the availability of program information – applications, informational materials, forms and brochures;
8. Prohibit discrimination based on race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, or disability;
9. Upon request, provide applicants with copies of all signed worksheets and documents; and
10. Explain to the client or guardian that discounted services may vary and that a rating based on financial resources will determine their portion of the bill.

Services

- Emergent/Urgent services must be provided
- Providers determine medical necessity
- All services normally provided at the facility should be available at a discount to CICP clients
  - Providers may set standardized policies that limit available services discounted under CICP

Excluded Services

- Non-urgent dental
- Nursing home care
- Chiropractic
- Cosmetic surgery
- Experimental/non-USFDA approved treatments
- Elective non-medically necessary surgeries
- Court ordered procedures (i.e. drug testing)
- Abortions except where required by law
- Mental health services as a primary diagnosis

Applicant Eligibility

- In general, ALL applicants 18 and older must:
  - Sign the Lawful Presence Affidavit indicating lawful presence status
    - This requirement does not apply after July 1, 2022
  - Provide one approved document demonstrating their lawful presence status
    - This requirement does not apply after July 1, 2022
  - Be a Colorado resident
  - Furnish a Social Security number
  - Meet all other CICP eligibility requirements (i.e. related to income, etc.)

Ineligible Applicants

- Applicants whose lawful presence status cannot be verified
  - These applicants are eligible beginning July 1, 2022
- Applicants in custody of a law enforcement agency
- College students from outside Colorado or the US who are in Colorado for the purpose of higher education
- Visitors from other states or countries
- Persons who qualify for Health First Colorado or CHP+

Colorado Residency

- An applicant is a Colorado resident if they currently live in Colorado and intend to remain in Colorado
- Applicants are allowed to self-declare their intent to remain in Colorado if they are unable to provide proof of their residency
  - This does NOT apply to college students
- Residency codes no longer exist in the Uniform Application, but are still included in the Clinic Client Application until 7/1

Household Size

- CLINICS: Board of Directors approved definition
- HOSPITALS: Any person living with the applicant can be included in the household.
- ALL PROVIDERS: All non-spouse or civil union partner, non-student, working age adults (18-64) must have supporte documented or attested to in order to be included in household size

Lawful Presence

- All applicants 18 and older must sign the affidavit and provide a lawful presence document
  - HOSPITALS: There is not an affidavit in the Uniform Application. You still need to have the household sign them. PDF versions are available on the CICP Provider Information website in English and Spanish.
- Providers establish lawful presence – not identity
- Any document recognized by the federal government as proving lawful presence is acceptable
- Lawful presence is no longer a requirement beginning July 1, 2022

Health First Colorado/CHP+

- Providers MUST screen applicants for eligibility for Health First Colorado and/or CHP+
  - Any applicant whose household income is more than 138% FPL (133% + 5% disregard) does not need to apply for Health First Colorado
- Children and pregnant women should ALWAYS be screened for Health First Colorado and/or CHP+
  - Any children or pregnant women who have private health insurance do not need to apply for CHP+
- HOSPITALS: None of these requirements are changing for CICP with Hospital Discounted Care

Denials

- Denial letter from state/county/PEAK etc.
- Letter from Connect for Health Colorado stating the applicant qualifies for subsidies
  - Do not qualify for subsidies if you qualify for Health First Colorado
- Denials due to refusal of the applicant to provide documentation are NOT sufficient proof that the applicant has been denied coverage
- Denial letters should only be accepted if they are dated within 45 days of the beginning of the application

Seniors and Medicare

- Issue for Seniors not applying for Medicare due to missing original application window and being subject to penalties
  - Penalties compound, sooner they apply the better
- For every year a Senior does not apply for Medicare:
  - Part A increases 10% for twice as long as senior waited
    - Example: Senior waited one year, pays 10% penalty for two years
  - Part B increases 10% for each year senior waited
    - Example: Senior waited three years, pays 30% penalty for as long as they have Part B

Application

- Applicant name
- Household address
- Name(s) of household member(s)
- Date of birth for all household members
- Health First Colorado/CHP+ ID numbers (if applicable and available)
- Social security numbers for all household members receiving services under the program
  - No SSN form for anyone in the household without a SSN

Uniform Application Household Codes

- Code Options:
  - 1 – Self/Patient
  - 2 – Spouse/Civil Union Partner
  - 3 – Parent/Guardian
  - 4 – Minor Child
  - 5 – Minor Sibling
  - 6 – Student Adult Child
  - 7 – Medical Power of Attorney
  - 8 - Other

Signature of Patient/Guardian

- Signature only on Application tab
  - Can be “signed” via email, portal, phone call, etc.
- Households must be informed within 14 calendar days of their rating or denial
  - Separate from what will be the Hospital Discounted Care determination notification

Electronic Signatures

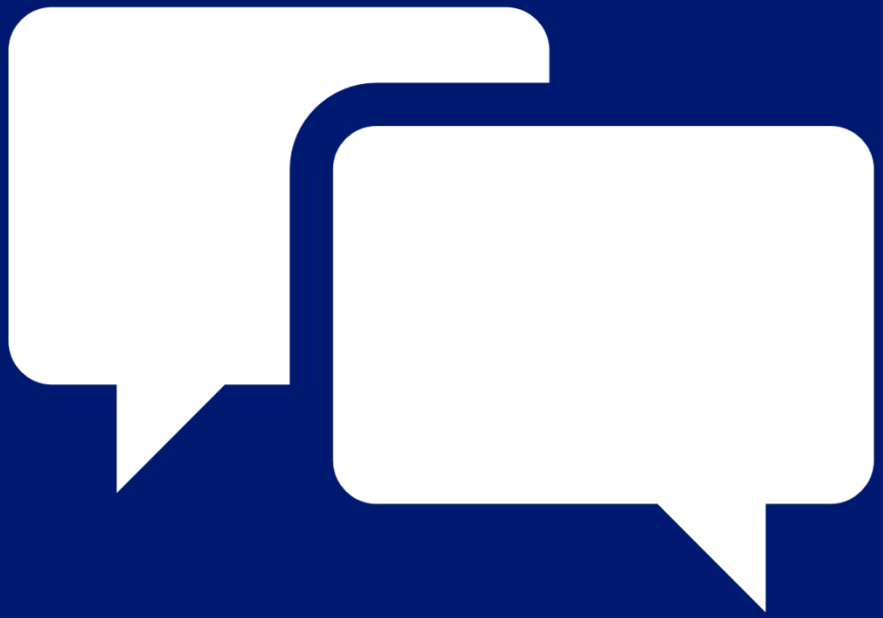
- Providers may utilize programs to collect electronic signatures for applications
  - Acceptable programs must have the ability to capture a date and time stamp for all signatures
- Entire "packet" can be signed once by the household and eligibility technician in lieu of signing each worksheet
- No SSN Form and Lawful Presence Affidavit must be signed separately from the "packet"

Emergency Application

- Emergency applications should only be completed by providers administering emergency services
  - Providers who have emergency departments
- Applicants can only utilize the emergency application once a year unless they are homeless
- Emergency application should only be used for applicants who appear not to be eligible for Health First Colorado and/or CHP+
- Indicate Emergency in notes section of Uniform Application

Health Insurance

- Applicants with private health insurance are eligible for CICP
- Providers must bill third party insurance before claims are written off to CICP



Household Financial Eligibility

- Three categories of income:
  - Employment income
  - Unearned income
  - Self-Employment income
- When calculating income, providers must obtain minimum amount of documentation to substantiate amounts

Employment Income

- Documentation may include:
  - 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
- Does not include those who work for cash

Self-Employment

- Documentation may include:
  - 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.

Cash Workers

- Documentation may include:
  - 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).

Additional Income

- Unemployment benefits information
- Short Term Disability information
- Letters for unemployed adult household members attesting they have no income

Documentation

- Providers shall obtain the minimum amount of documentation to substantiate amounts
- Applicants and other household members who are experiencing homelessness are exempt from income documentation requirements

Deductions

- Facilities may make additional deductions to a patient's household income based on existing, new, or updated policies
- There are no mandated deductions for CICP

“Spend Down”

- Household may pay part of their current bill in order to bring down the household FPG
- Payment would be entered as a deduction in Worksheet 3
  - Should be labeled “Current Bill Payment” or “CICP Spend Down” so it is clear what it is

Rating

- Ratings are not complete until the patient has provided all necessary documentation and the Facility has calculated their FPG
- Provider has 14 calendar days from the date the patient submits all required documentation to determine the household rating or denial and send notification to the patient

Effective Dates

- Ratings are valid for one year
- Beginning date of eligibility is the earlier of:
  - Date of the application (date application was started)
  - First date of service the application is being completed to cover

CICP Ratings and HDC

- Ratings for CICP clients that are prior to 6/1 (done on the CICP application rather than the Uniform Application) will need to be redone for households who seek service on or after 9/1
- Ratings for CICP clients that are completed between 6/1 and 8/31 may have HDC added to the card when services are provided on or after 9/1
  - Card effective date would change to DOS on or after 9/1, end date would stay the same

Ratings Prior to June 1

- Hospitals may use an application completed prior to June 1 to complete a new application for the household on or after 9/1
  - Information from original application would be entered into Uniform Application as applicable
  - Effective date on new card would be the DOS on or after 9/1
  - End date would not change
- Example: Household rated 4/2/22, new services on 10/5/22. New card would be effective 10/5/22 through 4/2/23.

Rerates

- Reasons for re-ratings may include one or more of the following:
  - Household income has changed significantly
  - Number of dependents has changed
  - An error was made in the original calculation
  - The rate year has expired
- Re-ratings reset the household copayment cap
- Re-rates are only applicable to any future services and do not change the copays due on past services

Other Provider's Rating

- Providers are NOT required to accept each other's rates if the provider believes:
  - The client's rate was determined inaccurately
  - The client was rated incorrectly
  - The other provider's deduction policy is different
- Providers should work out discrepancies in client ratings between themselves

Collaboration

- The Department strongly suggests that providers in similar areas exchange contacts that can be called if a client wants to use their card from one provider at the second provider and the second provider has questions about their rating
- This is only going to be more important going foward

Copayment Cap

- CICP copay cap remains at 10% of the household income
  - 10% or $120 for non-homeless households between 0 and 40% FPG, whichever is lower
  - OAP clients have $300 annual cap for each calendar year
- For HDC: CICP copayment caps will include any payment plans set up for CICP/HDC services provided at the provider's facility

Provider Management Appeal

- Every provider MUST have a designated employee who handles the Provider Management Appeals
- All providers MUST inform applicants of their right to appeal their rating in the case they believe their rating is incorrect
- Households have 30 calendar days from their rating/denial notification to file a request for a Management Appeal

Provider Management Exception

- Households with unusual circumstances may have justification for lower CICP ratings
- Households have 30 calendar days from their rating/denial notification or notice of a Provider Management Appeal determination to request a Management Exception
- Management Exceptions must be noted on the household application

Questions?

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Thank you!