Hospital Discounted Care

Policies and Procedures

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Agenda

- Policies and Procedures
  - Patient Rights, Provider Responsibilities
  - Screening, Determination, Notification
  - Billing, Payment Plans, Collections
  - Reporting
  - Appeals and Complaints
  - Compliance and Corrective Action
  - Rates
- Participation questions
- Questions

Hospital Discounted Care

General Rules

- Everything presented here today are minimum standards
  - If your facility already does better than these requirements, very few changes will be needed
- Providers MUST:
  - Use the Uniform Application
  - Screen all uninsured patients and insured patients who request to be screened
  - Limit payment plans to 36 months of payments and not exceed the monthly limits determined by the monthly household income

Patient Rights and Provider Responsibilities

Patient Rights

- At a minimum, Facilities must:
  - Post the Patient Rights developed by the Department in all required languages conspicuously on the Facility website
  - Make the information available in patient waiting areas
  - Make the information available to each patient or the patient's guardian, verbally or in writing prior to the patient leaving the facility
  - Inform the patient on their billing statement of the Patient Rights

Presentation of Patient Rights

- Facilities are allowed to change the format of the Patient Rights
  - Example: brochure
- Alternate formats for the Patient Rights must be submitted to the Department for approval
  - Alternate format must not change or omit any information
  - Information is not allowed to be placed into footnotes or other formats that downplay importance

Questions?

Patient Eligibility Requirements

Screening

- Patients provide self-attested information to the Facility in order to complete the screening
  - Screening must be provided in the patient's preferred language, using an interpretation service if necessary
- Patients have the right to refuse to be screened
  - Facility must collect a signed Decline Screening Form from the patient
- Facilities may only ask about household size and income; patients may not be asked about their assets or value of any assets.

Federal Poverty Guidelines (FPG)

- Federal Poverty Guidelines is a measure of income level issued annually by the US Department of Health and Human Services
- Hospital Discounted Care covers patients up to 250% FPG
  - The FPG is updated annually on April 1 to align with Medicaid
  - The Uniform Application will also be updated annually on April 1

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

Mandatory Inclusion

- 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
- Couples who are married must be legally separated or in the process of becoming legally separated to be rated separately

Other Household Members

- Minors should not have a determination completed separately from their parents unless there exists a special circumstance
- Unrelated members of religious orders must complete separate determinations
- 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 in the determination

Question 1

- A patient wishes to include their adult sibling that they live with in their application. The adult sibling agrees to be included. Does the patient have to attest that they are providing at least 50% of the support for their sibling?
  - A. Yes
  - B. No
  - C. Need more information

Answer 1

- A patient wishes to include their adult sibling that they live with in their application. The adult sibling agrees to be included. Does the patient have to attest that they are providing at least 50% of the support for their sibling?
  - A. Yes
  - B. No
  - C. Need more information

Question 2

- What additional information is needed?
  - A. Sibling's student status
  - B. Sibling's age
  - C. Explanation of why the siblings live together

Answer 2

- What additional information is needed?
  - A. Sibling's student status
  - B. Sibling's age
  - C. Explanation of why the siblings live together

Household Income

- Household income is a combination of earned and unearned income
- Earned 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
- Income from a working minor or an adult student living with their parents or guardians is exempt

Household Income (cont.)

- Unearned income includes:
  - 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.

Questions?

Screening Process

Screening Timeline

- Facilities have 45 calendar days from the date the of service or date of discharge, whichever is later, to screen the patient for:
  - Public health coverage
  - Discounted care through CICP
  - Hospital Discounted Care
- Patients may choose not to be screened
  - Must sign Decline Screening Form
- Facilities are encouraged to screen patients before they leave the facility if circumstances allow

Self-Attested Screening

- Facilities fill out the first tab of the Uniform Application using self-attested information from the patient
  - Other screening tools may be used if they cover all questions in the Uniform Application screening
  - Answers must be moved into Uniform Application
- Patients whose household income screens at or below 250% of the federal poverty guidelines (FPG) would qualify for Hospital Discounted Care

Households

- Not everyone listed on the screening may be included in every definition of household
  - Household definition is different for Health First Colorado than for CICP or Hospital Discounted Care
- Uniform Application is coded to help identify differences in household definitions and resulting FPG calculations

Other Health Coverage

- Patients are asked to provide previous Health First Colorado and/or CHP+ ID numbers
  - Easy for Facilities to check if their IDs are currently active
- Facilities must bill an insured patient's insurance prior to billing the patient
- Patients who decide to apply for Health First Colorado or CHP+ and are denied may request to complete an application for discounted care within 45 calendar days of the date of the denial

CICP and Hospital Discounted Care

- Patients who wish to apply for CICP or Hospital Discounted Care have 45 days from the date of their screening to provide all necessary documentation to complete the application
- Non-CICP participating providers must inform patients if they appear eligible for CICP and provide them with information on how to locate a CICP provider

CICP and Hospital Discounted Care (cont.)

- Patients who would potentially qualify for CICP or Hospital Discounted Care by not including other household members must be informed and allowed to apply separately
  - This does not apply to the patient or guardian's spouse or civil union partner or if the patient is a non-emancipated minor
- Patients should be informed that including any minor children in their household on the application will almost always be in their best interest

Screening Results

- Facilities are required to inform patients of their screening results
  - Provide information about what health care options they are likely eligible for
  - Provide information about how to apply for other coverage
    - Public health care
    - Discounted care
    - Health insurance marketplace

Decline Screening

- Uninsured patients who decline to be screened may request to be screened and apply for discounts within 30 calendar days of their billing date
- Decline screening forms generally only cover one episode of care and any related services
- One form may cover additional past dates of service if a form was not able to be collected for those earlier dates
  - Date range listed on the form can include multiple past dates of service
- Decline screening form may not be signed for future dates of service unrelated to past dates of service

Question 3

- A patient was in an accident that required surgery and follow up physical therapy appointments. The accident occurred on September 8, the surgery occurred on September 15, and the physical therapy visits ran from September 20 through October 25. Would a decline screening form signed on September 9 cover all of these services?
  - A. Yes
  - B. No

Answer 3

- A patient was in an accident that required surgery and follow up physical therapy appointments. The accident occurred on September 8, the surgery occurred on September 15, and the physical therapy visits ran from September 20 through October 25. Would a decline screening form signed on September 9 cover all of these services?
  - A. Yes
  - B. No

Retention

- Facilities must keep screening and decline 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

Screening Best Efforts

- Facilities must attempt to contact patients who have not been screened or signed a decline screening form
  - Contact attempts by at least one method of contact which should be the patient's preferred method
  - Contact attempts must be made at least once a month for six months after the patient's date of service or date of discharge, whichever is later
- Documentation of contact attempts kept in the patient's record will meet the screening requirements

Cease Contact

- Patients who request that the Facility cease contacting them related to completing the screening will be considered to have made an informed decision to decline screening
  - Documentation of the patient's request must be kept in the patient's record

Questions?

Application Process

Application

- Facilities must use the Uniform Application developed by the Department
- Applications can be completed before or after the patient has received care at the facility
- Patients will have 45 calendar days to submit any necessary documentation to complete the application after their screening
  - Patients who do not submit all the required documentation within 45 calendar days may need to submit updated documentation to complete the application

Household Documentation

- Facilities may request documentation to establish household size and income
- The following must be provided for all household members included in the application
  - First and last name(s)
  - Home address
  - Contact information
    - Email address, phone, etc.
  - Birthdate
  - Employer and Income information

Employed Members

- 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-Employed Members

- 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).

Questions?

Additional Income

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

Documentation

- Facilities shall obtain the minimum amount of documentation to substantiate amounts
- Patients 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 Hospital Discounted Care

Determination

- Determinations are not complete until the patient has provided all necessary documentation and the Facility has calculated their FPG
- Facility has 14 calendar days from the date the patient submits all required documentation to make a determination and send notification to the patient
- Facilities are responsible for notifying associated Licensed Health Care Professionals of the patient's determination

Effective Dates

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

Question 4

- What is the correct determination effective date for a patient who begins an application on October 10, receives services on October 21, sends all required documentation to the Facility by November 12, and has their application completed on November 16?
  - A. October 10
  - B. October 21
  - C. November 12
  - D. November 16

Answer 4

- What is the correct determination effective date for a patient who begins an application on October 10, receives services on October 21, sends all required documentation to the Facility by November 12, and has their application completed on November 16?
  - A. October 10
  - B. October 21
  - C. November 12
  - D. November 16

Question 5

- What is the correct determination effective date for a patient who receives services on December 12, is screened December 23, begins their application January 2, and sends in all necessary documentation January 5?
  - A. December 12
  - B. December 23
  - C. January 2
  - D. January 5

Answer 5

- What is the correct determination effective date for a patient who receives services on December 12, is screened December 23, begins their application January 2, and sends in all necessary documentation January 5?
  - A. December 12
  - B. December 23
  - C. January 2
  - D. January 5

Redetermination

- Redeterminations must be completed for any patient or guardian who requests
  - During original year of eligibility
  - During established payment plan
  - After additional unrelated services are provided
- Providers may not increase a patient's established payment plan if their redetermination results in a higher FPG
- Providers must lower the monthly payments if the redetermination results in a lower FPG
  - Months may not be added to the end of the plan

Question 6

- A household is currently in month 14 of their established payment plan. A household member seeks care in the ER and completes a new screening and application. Their determination is higher than the one related to their established payment plan. What happens to the plan?
  - A. Nothing, it remains the same for the duration of the 36 months of payments
  - B. It is adjusted to match the higher FPG
  - C. The Facility can adjust the current plan to include the new charges
  - D. Either A or C are acceptable

Answer 6

- A household is currently in month 14 of their established payment plan. A household member seeks care in the ER and completes a new screening and application. Their determination is higher than the one related to their established payment plan. What happens to the plan?
  - A. Nothing, it remains the same for the duration of the 36 months of payments
  - B. It is adjusted to match the higher FPG
  - C. The Facility can adjust the current plan to include the new charges
  - D. Either A or C are acceptable

Options

- Patient's first payment plan was $100 per month, redetermination is $120 per month
  - Leave first payment plan as is, begin second in parallel. Patient pays $220 per month for 22 months and then $120 for 14 months.
  - Combine plans - $2,200 remaining on first plan, $4,320 max for second. New plan is $181 per month for 36 months (reminder that first plan must be completed in 22 months)
  - Write off first plan and start new plan at $120 per month for 36 months

Questions?

Notice of Determination

Notice

- Facilities shall determine patient eligibility for the CICP and/or Hospital Discounted Care and send the determination notice within 14 calendar days of all documentation being submitted
- Written notification must be in the patient or guardian's preferred language and explain the determination
- Written notification should be sent through the patient or guardian's preferred method of contact

Eligible Patients

- Notice must include but is not limited to:
  - The programs and discounts for which the patient was determined likely eligible for, where to find additional information and how to apply for each program.
    - Any relevant application deadlines for programs the patient screened potentially or likely eligible for.
  - 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.

Eligible Patients (cont.)

- Notice must include but is not limited to (cont.):
  - 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).

Ineligible Patients

- 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, where to find additional information and how to apply for each program.
    - Any relevant application deadlines for programs the patient screened potentially or likely eligible for.
  - 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.

Ineligible Patients (cont.)

- Notice must include but is not limited to (cont.):
  - 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).

Determination Appeal

- Patients have 30 calendar days from the date of the notice to file an appeal
- Facilities may accept appeals filed after 30 days if there exists good cause
  - If the Facility denies an appeal filed outside the 30-day window, the Facility must inform the patient they have the right to appeal to the Department and provide the Department's contact information
- The Department has the final say on if the patient's untimely filing was due to a good cause

Notification of Licensed Health Care Professionals

- Facilities are responsible for notifying any Licensed Health Care Professionals who provided services to the patient of the patient's determination
- Notification should be made at the same time as the patient is notified
  - Facilities may set up a process to send weekly or bi-weekly reports of patients who have been screened, completed the application, and/or determinations made

Determination Card

- Determination card template available in Excel version of application
  - Shows patient eligibility for CICP and/or Hospital Discounted Care
  - Includes 4%/2% monthly maximum payment amounts
  - CICP copays and cap, if applicable
- Facilities may also create their own cards that show patient eligibility

Determination Card (cont.)

- Facility created cards must contain:
  - Patient's eligibility for Discounted Care and/or CICP
  - Calculated FPG
  - Effective dates of the determination
  - Household 4% and 2% limits
  - CICP copays and copay cap for the household if applicable
- Cards may also include patient's eligibility for Facility's internal charity care program so that one card template may be used for all patients
- Determination cards are optional

Determination Portability

- Allowable and encouraged to accept determinations from other Facilities
  - Copy of the notice or card must be kept in patient's record
- Facilities may include their own list of deductions, so determinations may vary from Facility to Facility
- Facilities may contact another Facility that has completed a determination for a patient to request the application and supporting documentation in order to complete a determination for the patient at their Facility

Questions?

Billing

Timing of Bills

- Bills should not be sent until a patient is screened or has signed a Decline Screening Form
  - Bills must not be sent until the 46th day past the patient's date of service or date of discharge, whichever is later
  - Bills may not be sent during the time a patient is waiting to be screened or actively completing the discounted care application

Charged vs Billed Amounts

- Providers must bill patients according to the rates set by the Department
  - Charges stay the same and are what should be reported to the Department during data collection
- Rates set by the Department are maximums – Providers are allowed to bill less
- Payment plans for patients may be less than the established rates even at the maximum payment plan
  - Providers may include the difference between the allowed billed amounts and the payment plans in their data reported to the Department

Related Charges

- All services provided related to the same episode are considered one episode of care
  - Payment plan applies to all services under one episode of care
- Example: A patient was in an accident and sustained injuries that required surgery and follow up physical therapy. The surgery and all associated physical therapy visits would fall under the same determination and payment plan

Third Party Payments

- Third party insurance must be billed if the patient is covered prior to billing the patient
- Insured patients have 45 calendar days from the date of their bill after their insurance adjustment to request to be screened
  - Facilities have three business days to respond to the request and set up the patient's screening
- Insured patient's bill would be the lesser of:
  - Remainder of bill after insurance adjustment
  - Patient's copay and/or deductible
  - Rate set by the Department

Payment Plans

Payment Plan General Rules

- Providers must allow eligible patients to set up payment plans
- Providers cannot send patients to outside institutions to obtain loans to cover their bills
  - Includes loans from banks and other creditors like CareCredit
  - Creditors who offer 0% interest credit that agree to follow the Hospital Discounted Care rules around length of plans and maximum monthly amounts are allowed

Payment Plan General Rules (cont.)

- Payment plans must not exceed:
  - 4% of the gross household income for bills from a Facility
  - 2% of the gross household income for bills from each Provider who bills separately from the Facility
  - 36 months of payments
- These are maximums – Providers may set up payment plans that are less per month or for a fewer number of payments based on new, existing or updated policies

Payment Plan Structure

- Providers should contact patients within 30 calendar days of their determination to set up a payment plan
  - Patients have 181 calendar days past their date of service or date of discharge, whichever is later, to make a payment
- Patients who wish to pay off their bill at once would be responsible for at most what their payment plan would be at the full 4%/2% for 36 payments

Plan Structure

- The allowed billed rate may be less than what would be allowed under a full payment plan
  - Plans would be able to be made for less monthly for the 36 payments, or up to the 4%/2% limits for fewer months
- Patients are not required to complete a redetermination at any point during their established payment plan, but may request to be redetermined at any time
  - Higher redeterminations change nothing about a patient's established payment plan
  - Lower redeterminations potentially result in a lower monthly payment amount with no additional months

Upfront/"Paid in Full" Options

- Providers may offer discounted bills for Hospital Discounted Care patients that wish to pay their bills prior to services being rendered
  - The most this payment can be is what the patient would pay at the full 4%/2% limit for 36 months or the allowable billed amount, whichever is lower
- Example: If a patient would pay $150 per month on the maximum payment plan, their "paid in full" bill could be no more than $150 x 36 months = $5,400

Completion of Plan

- Payment plans are considered complete after the patient has made 36 months of payments or paid the full amount for which they were billed, whichever is earlier
- Patients are allowed to pay more towards their bill in order to pay their plan off sooner

Payment Plan Examples

- Situation: a household of five completes a determination and are found to have an FPG of 215 and a 4% monthly payment limit of $232. One of the parents has a scheduled surgery and the other ends up with an emergency procedure the following month before the household has set up a payment plan for the scheduled surgery.

Question 7

- Which of the following would NOT be an acceptable payment plan for this household?
  - A. $232 for 36 months = $8,352 total
  - B. $400 for 36 months = $14,400 total
  - C. $500 for 30 months = $15,000 total
  - D. $464 for 36 months = $16,704 total
  - E. All are acceptable

Answer 7

- Which of the following would NOT be an acceptable payment plan for this household?
  - A. $232 for 36 months = $8,352 total
  - B. $400 for 36 months = $14,400 total
  - C. $500 for 30 months = $15,000 total
  - D. $464 for 36 months = $16,704 total
  - E. All are acceptable

Questions?

Collections

Collections Process

- Before collection actions can begin, Providers must:
  - Screen uninsured patients and insured patients who request for eligibility for public health coverage and discounted care
  - Discount charges for any patient determined eligible
  - Provide in the patient's preferred language and in plain language an explanation of the bills and charges and notify the patient of potential collection action
  - Bill any third-party payer that is responsible for providing health care coverage to the patient

Collection Process (cont.)

- Letter informing patient of potential collection action must be sent at least 30 days prior to the actions being started
- Collection actions may not begin until 182 calendar days after the patient's date of service or date of discharge, whichever is later

Collection Amounts

- Patients may not be sent to collections for amounts higher than the Department set rate minus any payments from the patient or a third-party payer
- Patients may not be sent to collections seeking the full amount of their care

Collections for Patients with Payment Plans

- Providers may not start collections actions against patients with payment plans until the third consecutive missed payment or 182 calendar days past their date of service or date of discharge, whichever is later
- Notice of collection actions may be sent after the second missed payment but not before 152 calendar days past the patient's date of service or date of discharge, whichever is later

Collection Action Notification

- Notification letter must include an opportunity for the patient to report a change in household or income and request a redetermination
- If a change has occurred, the Facility must complete a redetermination for the household and adjust the remaining payments accordingly
- Licensed Health Care Professionals must inform the Facility of any patient reported change so that the Facility may contact the patient to complete the redetermination

Reporting Requirements

Reporting

- Beginning in 2023, Facilities will be required to report data to the Department related to Hospital Discounted Care
- Data is required to be disaggregated by race, ethnicity, age, and primary language spoken
  - If a Facility does not have the ability to disaggregate the data by these categories, the Facility must report what steps are being taken to improve data collection and the date by which the Facility expects to be able to report the data as required

Data Points

- 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

Data Points (cont.)

- 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

Data Points (cont. 2)

- 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

Data Points (cont. 3)

- 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

Questions?

Appeals

Ineligible Determinations

- Patients found ineligible for discounted care have the right to appeal
- Facilities must inform patients on their determination notice of their right to appeal their denial

Appeal Process

- Appeal process:
  - Patient has 30 calendar days to appeal in writing to the Facility
  - Facility must confirm receipt of the appeal within three business days and has 15 calendar days to complete a redetermination and inform the patient and the Department of the results
  - Patients may appeal to the Department if the Facility upholds their initial determination
  - Patients have 15 calendar days to appeal to the Department
  - Department has 15 calendar days to review the documentation and make a final determination

Incorrect Information

- Patients may appeal a determination that was completed using incorrect information that resulted in a higher determination and payment plan
- Facilities must complete a redetermination for any patients whose determination was based on incorrect information provided by the patient based on a misunderstanding of what was required
- Appeals process is the same as outlined previously

Non-Receipt of Notice

- Patients may file an appeal if they do not receive a determination notice within 15 calendar days of submitting their documentation
  - Patient has 60 calendar days from the date they submitted their documentation to file the appeal
- Facility must review and respond to the patient and the Department within 15 calendar days

Department Monitoring of Appeals

- Department will keep records of all appeals and their final determinations for each Facility
- If a repeated pattern of errors is detected, the Facility will be required to attend additional training with the Department
- The Facility may be subject to random application checks for 12 months following the training to ensure errors have been corrected

Complaints

Complaints to Department

- Department has set up a complaints process for patients who feel a Provider is noncompliant
- Patients can file complaints to the Department without filing complaints to the individual Provider
- Department will conduct a review within 30 calendar days of any complaint received

Department Monitoring of Complaints

- Department will keep records of all complaints filed against a Provider
- If a repeated pattern of errors is detected, the Provider may be subject to a corrective action plan
- Providers will have 90 calendar days to submit their corrective action plan

Compliance and Corrective Action

Audits

- Department will periodically audit Providers to ensure compliance with Hospital Discounted Care rules and policies
- Providers determined to be out of compliance will be notified by the Department
- Providers will have 90 calendar days to submit a corrective action plan

Fines

- If a Provider's noncompliance is determined to be knowing or willful, or if there is a repeated pattern of noncompliance, the Department may fine the Provider up to $5,000
- Providers who fail to take corrective action or file a corrective action plan may be fined up to $5,000 per week until the Provider takes corrective action

Rates

Rate Setting

- Rates will be set annually by the Department
- Rates are determined by using the higher of the Medicare and Medicaid Base rates
- New rates will be published July 1 each year using the most recent Medicare information as of April 1 each year

Inpatient Service Rates

- Inpatient rates are used for patients who have health care provided in a hospital and are discharged after 24 hours
- Rates vary from Facility to Facility

Outpatient Service Rates

- Outpatient rates are used for patients who have health care provided in a hospital or a free-standing emergency department and are discharged in less than 24 hours
- Rates vary from Facility to Facility, with the exception of a subset of clinical diagnostic laboratory service rates

Professional Services Rates

- Professional rates are used for patients who have health care provided by a licensed health care professional during a hospital or free-standing emergency department visit
- Professional rates do not vary by location and are the same statewide

Questions?

Contact Info

Taryn Graf
CICP Administrator

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Thank you!