Hospital Discounted Care

Question & Answer Session

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General

What is the delayed start date?

- House Bill 22-1403 has delay the start date from June 1 to September 1, 2022.

Are CICP facilities still starting this process 6/1/22?

- CICP providers began using the Uniform Application on June 1, but the Hospital Discounted Care portion of the application and rules does not go into effect until September 1. Please refer to the CICP Provider training slides on the CICP website at https://hcpf.colorado.gov/cicp.

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Would we skip the screening questions on the uniform application for CICP sites beginning 6/1, and then start screening patients 9/1?

- There is no harm in completing the screening questions beginning 6/1, as CICP Providers already screen for all the other public health coverage programs. Completing the screening questions would be easiest, as they are coded to pull over to the Patient Information tab.

Not all providers must take CICP but all providers must comply with HDC?

- All CICP providers are HDC providers, but not all HDC providers are CICP providers.
- Hospital Discounted Care applies to:
  - General acute and critical access hospitals
    - Outpatient facilities licensed as an on campus department or service of a hospital or that is listed as an off campus location under a hospital's license
    - Does not include FQHCs or student-learning medical and dental clinics that offer discounted care and are physically situated within a health science school
  - Free-standing emergency departments
  - Licensed Health Care Professionals who work within these settings

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Does HDC apply to all facility visits? Specialist appointments, elective, etc.?

- Per the bill, HDC applies to “emergency and other non-CICP health care services”

What about third party contractors who work within a facility?

- Licensed Health Care Professionals must abide by Hospital Discounted Care rules
- Other third party companies who bill separately from the facility are not covered under Hospital Discounted Care

Will there be additional training prior to 9/1?

- The Department is planning on holding additional training sessions during the summer in addition to holding office hours
- Providers may send any requests for training topics to the hcpf_HospDiscountCare@state.co.us inbox
- Training sessions have been recorded and will be available on the Hospital Discounted Care website soon

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Where can we find the resources?

- Everything is available on the Hospital Discounted Care website: https://hcpf.colorado.gov/hospital-discounted-care
  - Patient's Rights
  - Decline Screening Form
  - Uniform Application
  - Operations Manual
  - Training Slides (and recordings soon)
  - Rates
  - Frequently Asked Questions

Is the Uniform Application also the screening tool?

- The first tab of the Uniform Application contains the screening questions, and those must be filled out to complete the screening process

Can hospitals still ask about liquid resources for their own internal charity care?

- Hospital Discounted Care's income rules only apply to patients who are requesting to screen and apply for Hospital Discounted Care. If a patient applies and is found to be over income, or if a patient does not want to apply, the facility may apply their own charity care rules for the patient.

How would you suggest to explain the difference between CICP and HDC?

- CICP copays will almost always be less than what would be required under HDC
- Some services are not CICP-eligible
- Eligibility wise, there is not much different. All CICP patients will qualify for HDC, but not all HDC patients will qualify for CICP.
- To be eligible for CICP, the patient must:
  - Apply for Health First Colorado/CHP+ if they appear eligible or provide a denial letter dated within the last 45 days
  - Provide a SSN or sign the “No SSN” form

Would we still need to supply a Good Faith Estimate under the No Surprise Billing Act?

- Hospital Discounted Care does not change any requirements for Providers under other state or federal rules, laws, or regulations.

Patient Rights

Do all patients receive the Patient's Rights document?

- As required by HB 21-1198, all patients must be provided with the Patient's Rights document

Does the Patient's Rights document have to be signed?

- No, the document does not need to be signed

Do you need to document that you gave a patient the rights?

- There is no documentation requirement for this, but Providers should ensure that it is incorporated into their policies to hand out the Patient's Rights document to patients at their facility in order to comply with the law.

Will the Colorado residency requirement be updated on the Patient's Rights document?

- This change has been made and the updated document is available on the Hospital Discounted Care website
- The document has also been updated to reflect the September 1 implementation date

Household

Households can be very complex. Medicaid goes off of tax filing status. How does CICP/HDC differ?

- HDC and CICP allow for any person living at the patient's address to be included in their household. Households may also include family members who live outside the state or country that have at least 50% of their support provided by the patient or guardian.
- Spouses/civil union partners must be included
- Income from all adult household members must be included – this includes for members living outside the state or country.
- Screening helps define the various households

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How do they prove they're supporting family outside the state or country?

- Providers may ask for the patient to have their attestation notarized if they choose

Counting family in other countries does not match Medicaid rules, so how does that work?

- The household definition for CICP and HDC is different than Medicaid's definition. The screening tab is coded to make preliminary eligibility determinations based on various household compositions.

What if some of the household members are undocumented?

- Lawful presence is not a requirement for CICP beginning July 1, 2022, and it will not be a requirement for Hospital Discounted Care. Therefore, household members who are undocumented may be counted in the households for both.

If there are multiple families in one household, is it a requirement to provide all their income?

- If the families are opting to apply as one household, income from all working age non-student adults would need to be included
- It will most likely be better for families to apply separately
- The patient or guardian would need to attest they are providing at least 50% of the support for the adults in the other family for them to be included

How can we tell if someone does not want to be included in the household?

- Any adult included in the household must provide their income information, so if income information is not provided it can be assumed the household member does not want to be included

If a married couple is living separately, does that count as them being legally separated?

- No, married couples wishing to be rated separately must provide a court document showing their legal separation, or documents they have submitted showing they are in the process of becoming separated. They may also have their lawyer write a statement that they are in the process of separating.

What about a patient that has a spouse incarcerated and is supporting them?

- Per Colorado law, all married couples must include both spouses on the application. The incarcerated spouse would be listed as a household member only and would not be eligible for Hospital Discounted Care or CICP.

Can an 18-year-old college student living on their own apply as a household of 1?

- An adult student would be able to apply on their own if they choose. Any income they have would be included in the application.

Do we count the parent’s income for the 18-year-old adult student living on their own if the parents are supporting them?

- In this situation, if the adult student wants to apply on their own, they would be allowed to. Similarly, if the parents wanted to apply, they could include the adult student in their household as long as the adult student consents to being included and considers the parent’s home as the student’s permanent address

What about an adult student from another country that is receiving a stipend from a family member and has no other income?

- In this situation, the adult student would not be a Colorado resident. However, if the facility chose to allow them to apply for Hospital Discounted Care, the stipend from the family member would not be counted as income.

Are minors who are seeking confidential care allowed to apply on their own?

- Minors are allowed to be rated separately from their parents or guardians in certain situations, including but not limited to:
  - if the minor is a parent and is seeking care for their child,
  - for the examination and treatment for sexually transmitted diseases,
  - for the examination and treatment for alcohol and/or drug addiction,
  - obstetrical and gynecological procedures, birth control procedures, supplies, or information
  - voluntary mental health services (minor must be 15 or older)
  - Confidential Teen Services Program

How are accounts of deceased patients handled?

- A family member or other representative may complete a screening and application for a deceased patient. The person completing the application is not responsible for the patient's bills. Providers will need to follow up with the patient's spouse or executor of their account to seek payment

Income

Do all household members need to verify their income?

- The screening is all self-attested information, so no verification will be needed during that process.
- If the household decides to complete the application, all non-student working adult household members will need to submit documentation of their income.

Can the patient state that another household member has no income?

- During the screening process, this would be acceptable. If the household decides to complete the application, any household members who have no income could be asked to submit a letter stating they have no income. Providers would be allowed to ask household members to have those letters notarized.

If a household member provides paystubs, do we need one or a month's worth?

- If the paystub has a YTD line on it, one is sufficient because it includes income for the entire year to date.
- If the paystub does not have a YTD line, it is best to get a least a months' worth if possible. The more paystubs they have, the better the calculation is going to be.

What if the spouse refuses to provide their income?

- In the situation where the patient or guardian's spouse refuses to provide their income information, the applying spouse will need to make their best guess as to what the spouse's income is. Documentation that the spouse refused to cooperate and that the income is a guess should be kept in the application.

Do we count income from a spouse living in another country?

- If the spouse living outside the country has additional income, it should be counted. Providers would need to ensure that amounts are converted into dollars. Providers are also reminded that these are maximums, and facilities may set policies not to count income from a spouse living in another country.

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If a household member is paid in cash, how is that documented?

- There are various acceptable documentation methods listed in the Operations Manual for household members paid in cash:
  - 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)

What is acceptable for self-employed household members who don't have P&Ls, bank accounts, or file taxes?

- Self-employed household members may submit lists of income and expenses they have as their documentation of their business financials. Even if they do not normally keep profit and loss statements for their business, they would be allowed to create one as documentation. It would be challenging to use bank records for an account that is a mixture of personal and business, but that would also be an acceptable form of documentation.

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Are we allowed to use bank statements if we aren't allowed to ask about assets?

- Patients are allowed to use bank statements as documentation of income if they are self-employed or work for cash. Providers would ONLY be allowed to use what the patient indicates as income and expenses on the statements, NOT the full amount of the account. Patients would be allowed to redact the account balance and any other information not directly related to their employment or business.

Would the patient be allowed to redact the bank account number?

- The patient would be allowed to redact the account number, it is not needed for the application. However, their name should be visible on the statement.

Can we use tax information at any point of the year?

- Providers may use taxes as documentation at any point of the year, and they may also set policies to only use taxes during certain parts of the year. For some patients, taxes really are the best way to get a full picture of "normal" annual income, especially for those who are seasonal workers or whose business fluctuates throughout the year (e.g., farmers).

What unearned income sources can be counted?

- Unearned income sources included in household income are:
  - 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

Is child support considered either income or a deduction?

- Child support is not one of the allowed unearned income sources. Providers are allowed to set their own deduction policies.

Patient Eligibility

What are the residency requirements to receive Hospital Discounted Care?

- Patients must be Colorado residents to be eligible for Hospital Discounted Care. As this is a minimum standard, facilities are allowed to extend Hospital Discounted Care to non-residents as they see fit for their facilities.

If a patient's address is outside of Colorado, do we need to screen them?

- The bill states that all uninsured patients must be screened or complete an opt out form.

If a patient resides in Colorado more than half the year, they are a Colorado resident correct?

- Correct, someone who resides in Colorado for at least half the year is considered a Colorado resident.

Are undocumented patients eligible for Hospital Discounted Care?

- There are no lawful presence requirements for Hospital Discounted Care, and lawful presence will no longer be a requirement for CICP beginning July 1, 2022. These patients would be eligible for both once Hospital Discounted Care begins in September.

How is someone a Colorado resident if they are not lawfully present?

- Residency and lawful presence are two separate things. Someone may be:
  - A Colorado resident and lawfully present
  - A Colorado resident but not lawfully present
  - Lawfully present but not a Colorado resident
  - Neither a Colorado resident nor lawfully present
- Residency is established simply by being in the state and declaring intent to stay

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If a patient is eligible for Health First Colorado, can they be denied Hospital Discounted Care?

- Facilities are not allowed to mandate that a patient or household apply for public health care coverage prior to approving them for Hospital Discounted Care. It is the patient's choice as to what they apply for to cover their visit. Facilities should explain the advantages of being a Health First Colorado member to the patient, including that it has set benefits and much lower copays than would be available under either Hospital Discounted Care or CICP.

If a patient provides an out of state ID but a Colorado address, what do they need to provide to prove residency?

- There are a lot of options for documents that may prove residency, including bills with the Colorado address on them, a rental or mortgage statement, the patient’s pay stubs showing their home address, etc. However, a patient who cannot provide a document showing their Colorado address may self-declare their intent to remain in the state to establish residency.

Some patients may be hesitant to apply due to immigration fears. Is any of this information reported to the federal government?

- The Department will never possess a list of patients who have been screened, applied for, or are currently utilizing Hospital Discounted Care. The data that will be reported to the Department will all be aggregate information with PHI removed. The Department also wants to reiterate that Hospital Discounted Care is not a program, care is still technically being provided under individual provider internal charity care programs.

Does Hospital Discounted Care apply to insured patients?

- If an insured patient requests to be screened and complete an application and is determined eligible, their services must be discounted under Hospital Discounted Care.

Can a patient have Hospital Discounted Care at more than one facility?

- A patient may complete the screening and application processes at more than one facility and have multiple determinations and/or cards.

If a patient has Medicaid but is here for law enforcement medical clearance, Medicaid is removed since they do not cover police services. Would the patient need to be screened?

- In this case, the law enforcement organization is responsible for the patient's medical bills, so a screening is not required. The patient's medical clearance services would not be eligible for Hospital Discounted Care or CICP.

Screening

Is there a definition of uninsured?

- “Uninsured individual” means an individual who does not have creditable coverage.
- “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).

Do we screen patients every time they are seen?

- A household's screening only covers one episode of care UNLESS the household applies and is found eligible for discounted care, in which case their eligibility generally lasts for a year. If a patient is screened and decides not to apply for discounted care, they would need to be screened again the next time they are seen. Similarly, if a patient declines to be screened, they would need to be screened or sign another decline screening form when they are seen again.

We have a hospital and clinics, will each visit at any of our locations have to have a screening or opt out form?

- Hospital Discounted Care applies to any clinics that are operating under the Hospital's license, so any visit at these facilities will be subject to the screening requirements.
  - Does not apply to FQHCs or student learning medical and dental clinics with their own discounted services provided as part of the student learning and which are physically situated within a health science school.

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If we screen for Health First Colorado and determine the household is eligible, do they still need to be screened for HDC?

- The screening covers both public health care coverage and discounted health care, so using the screening tool in the Uniform Application will screen for Health First Colorado and Hospital Discounted Care simultaneously. Households who choose to apply for Health First Colorado do not need to also apply for Hospital Discounted Care, unless the household is denied coverage under Health First Colorado.

Will CICP still require an applicant to apply for Health First Colorado if they appear eligible?

- Patients who appear eligible for Health First Colorado will be required to apply and obtain a denial prior to being placed on CICP. Patients who appear eligible and choose not to apply for Health First Colorado would still be eligible for Hospital Discounted Care.

Can a different screening tool be used?

- Providers are allowed to use existing or updated screening tools, however it is mandated in the bill that the screening tool contained in the Uniform Application be used. Therefore, patient responses to screening questions would need to be transferred into the Uniform Application to comply with the bill.

What happens if a patient leaves the hospital without being screened or signing the decline screening form?

- Providers will need to begin the Screening Best Efforts process outlined in the Operations Manual for any patient who is discharged or otherwise leaves the facility without being screened or signing an opt out.

Why do we have to continue contact attempts for six months?

- Per the bill, facilities must screen the patient or collect a decline screening form prior to sending the patient to collections. Collections processes cannot start until 182 days past the patient's date of service or date of discharge, whichever is later. Continuing contact efforts during the time the patient cannot be sent to collections shows that the provider did everything they could to screen the patient for discounted care.

What documentation of screening best efforts is required/sufficient?

- Documentation includes but is not limited to logs of phone calls and whether voicemail messages were left, copies of text messages sent including the dates/times they were sent, copies of emails sent including the dates/times they were sent, and copies of patient portal messages or notices including the dates/times they were sent or posted.

Is the patient's preferred method of contact included in the application?

- There is a question about the patient's preferred method of contact in the screening part of the Uniform Application. That information pulls over to the Patient Information tab that is part of the application.

If a patient is not responding to their indicated preferred method of contact, do we need to try another?

- The Department was informed that providers have internal policies related to contacting patients and moving through the various contact information on file for patients who are not responding to one method of contact. Providers should continue to follow their internal policies in these situations.

If a patient decides to apply for Health First Colorado instead of HDC, do they need to sign a decline screening form?

- This is going to depend on when the patient decides they are going to apply for Health First Colorado. If they complete the screening, are found likely or potentially eligible for Health First Colorado, and make the decision then, there is no need for the opt out as they have completed the screening. If they decide on their own prior to screening that they want to apply for Health First Colorado, they would need to sign a decline screening form.

If a patient is screened and qualifies for Medicaid or other programs, can we refer them to the county to apply or do we have to help them apply?

- Providers who are not currently MA/PE/CAAS sites can continue to direct patients who wish to apply for Health First Colorado or other programs to the places they are currently referring them to. There is no requirement in the Hospital Discounted Care rules or regulations that stipulate that a Provider assist the patient in applying if it is not something they don’t already do.

If the patient already has a current CICP rating, do we need to do a screening?

- If a patient already has a CICP rating and the facility is going to accept that rating, there is no need to do a screening. The facility will need to ensure a copy of the patient's CICP card is kept in the patient's record.

If a patient has already been screened at another facility but cannot produce their determination notice or card, should we screen them again?

- Providers would be able to screen the patient again, or, if the patient consents, the second facility may contact the first facility to obtain the patient's determination or application packet.

If a screening is completed over the phone and the patient declines to apply for discounted care, how do we document that?

- Providers are not required to document when a patient decides not to complete an application, only when a patient decides not to complete a screening..

If all information is self-attested, how do we know the household is being truthful?

- Self-attested information applies only to the screening. If the household decides they want to apply for discounted care, they will need to provide documentation of their income.
- This requirement does not apply to patients who are experiencing homelessness. Those patients are allowed to use self-attested information for both the screening and application processes.

What if a person experiencing homelessness is discharged before being screened or signing the decline screening form?

- Providers should follow their internal policies on how to contact patients who leave without indicating a preferred method of contact or even leaving contact information at all.

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Can others opt out or request screening for a patient?

- The patient’s spouse, other family member, or medical durable power of attorney may sign a decline screening form or complete a screening and/or application for a patient.

How will I know if a patient appears to be Health First Colorado eligible?

- The screening tool will calculate a preliminary eligibility determination using the household information entered. It helps identify when some household members may not be included in Medicaid’s definition of household, and calculates the FPG. It will then say if the household is potentially, likely, or likely not eligible for Health First Colorado. Note these are preliminary and not an official determination.

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Should the process for screening be Health First Colorado, CICP (if applicable) and then HDC?

- The screening process included in the Uniform Application will screen for all three of those simultaneously. That is the correct order for best situation for the patient, as Health First Colorado would be the most beneficial for them, followed by CICP and then Hospital Discounted Care. If the patient appears to qualify for Health First Colorado, they would not be able to apply for CICP until a denial is received.

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What about screening for the other various Health First Colorado programs?

- The screening built into the Uniform Application is designed to identify MOST of the patients who qualify, however there may be some patients with additional circumstances that would qualify for other Health First Colorado programs (MSP, LTC, OAP, WAwD, etc.). Providers should do their best to identify these patients and encourage them to apply for the programs they appear they may qualify for.

Does the 45-day screening window start over with every new visit if the patient is not responding to contact attempts?

- The 45-day window is a timeframe during which the provider should do everything they can to screen a patient prior to sending a bill. If a patient continues to obtain services and avoid screening attempts, the window does not start over with each new visit regarding being able to send bills. Bills for each visit would be able to be sent on the 46th day past the visit. Technically patients have at least 181 days to request to be screened and start an application.

For insured patients, when does the screening have to take place?

- Providers have three business days from the day the insured patient requests to be screened to contact the patient to set up a screening. The screening does NOT have to take place within three business days. Screenings should be scheduled within 45 days of the Provider contacting the insured patient to set up the screening. The patient may not be sent additional bills during the screening and/or application process.

Why would we screen a patient who is not a Colorado resident?

- The law stipulates that all uninsured patients must either be screened or sign a decline screening form. Completing a screening for a non-Colorado resident creates documentation for the Provider that they completed the screening as required by law and also creates documentation that the patient is from out of state.

Decline Screening

Is there a recommendation on how we should ask uninsured patients if they want to opt out?

- Providers should be asking the patient if they want to be screened for discounted care, not if they want to opt out. If the patient does not want to be screened, at that point the Provider would present the opt out form for the patient to sign.

What if a patient refuses to sign a Decline Screening Form?

- Patients who do not wish to be screened but refuse to sign a decline screening form prior to leaving the facility would fall into the Screening Best Efforts process. The facility would need to contact the patient to attempt to get them screened or sign an opt out form. If the patient declines again, the facility would need to document the patient's declination (email, portal message, note taken after a phone call, etc.) in order to meet the screening requirements.

If a patient refuses to sign the opt out and they are not a Colorado resident, do we have to screen them?

- All uninsured patients must be screened or sign the Decline Screening Form regardless of their residency status. If the patient refuses to sign the opt out and has not been screened, Providers will need to begin Screening Best Efforts.

Does the Decline Screening Form need to be signed every time the patient is seen?

- A Decline Screening Form generally only covers one episode of care and all related services, and therefore will need to be collected for each unrelated episode of care. If a patient has not signed a Decline Screening Form and has had several visits, the one form may be used for all past visits by indicating the date range the patient is opting out of screening on the form. Patients may not sign a form opting out of screening for future visits.

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Does the Decline Screening Form need a wet signature?

- Providers may collect electronic signatures for the Decline Screening Forms.

If the patient is unresponsive, not signing or responding to contacts, can you bill the patient for charges?

- Providers are allowed to send the first bill for the patient's services beginning on day 46 past the date of service or date of discharge, whichever is later. The bill must contain the patient's rights information and information on how the patient can request to be screened.

Can the Decline Screening Form be converted into an electronic form?

- Facilities are allowed to convert the Decline Screening Form into a form that may be signed electronically as long as no information on the form is omitted or changed.

Does a patient who already has a CICP or HDC determination need to opt out of screening?

- If a patient has a current CICP or HDC determination, the facility would be able to collect a copy of their determination notice or card for their patient record and would not need to screen them again. Facilities may choose to rescreen a patient and have them complete a new application if the facility believes they include different deductions than the facility that completed the original determination.

If multiple members of the same household receive services on the same day, would they be able to complete one opt out form?

- In this situation, one opt out form would be acceptable. Facilities should ensure that all household members’ names who received services are listed on the Decline Screening Form.

Can a patient sign the opt out form electronically if they complete the screening over the phone and decide not to apply?

- Patients who are screened do not need to sign the Decline Screening Form since they have completed the screening. If a household decides not to complete an application after they have been screened, the facility does not need to have any documentation of that decision. Facilities are responsible for screening uninsured patients and completing applications for patients that request to apply.

The opt out form has a place for a staff signature. Does this have to be signed?

- The Decline Screening Form must be signed by the staff member who explains discounted care and the form to the patient. The signature indicates that the staff member ensured the patient understood what it is they were opting out of.

Application

What happens if the household does not submit all the required documents?

- Households have 45 days from the day the application is started to submit all required documentation. If some documentation is missing at the 46-day mark, the facility may request updated documentation to complete the application with.

What if a non-resident wants to apply?

- Patients who complete a screening and are found to be non-Colorado residents should be informed that they are not eligible for Hospital Discounted Care. Providers may allow non-residents to be eligible if they choose, in which case a non-resident would be treated the same as a resident for the application process.

How many days does a patient actually have to apply?

- Providers must screen patients within 45 days, at which point they must begin Screening Best Efforts. Patients have 45 days to complete an application once it is started. Providers may not send a patient to collections until 182 days past their date of service or date of discharge, whichever is later. Patients may request to be screened and request to complete an application at any point prior to their account being sent to collections.

If the household requests to be screened or apply at day 180 and then fails to complete their application within 45 days, what happens?

- If the household’s 45-day period ends after 181 days past their date of service or date of discharge, whichever is later, and they have not supplied the required documentation to complete the application, the provider would be allowed to commence collections proceedings.

How long is Hospital Discounted Care active once the patient qualifies?

- The household's Hospital Discounted Care determination is generally valid for a year total, with the start date set to the earlier of the application date or the date of service the household is applying to cover. Providers may have internal policies that extend the effective period.

Does Hospital Discounted Care backdate?

- The effective date of the determination is the earlier of the application date or the date the household is applying to cover. In this sense, Hospital Discounted Care does backdate. Since households can request to be screened and apply at any point prior to their account going to collections, the “backdate” can be up to 181 days or longer if the provider allows them to apply after that date. There will no longer be a standard 90 day backdate for CICP.

Can HDC be retro prior to when it becomes effective?

- Hospital Discounted Care will become effective on September 1, 2022. Providers are not required to discount services provided prior to that date but would be allowed to cover previous dates if they choose.

Can a household request to be screened or complete an application without a recent visit or admission?

- Facilities will be allowed to set policies related to whether their facility will complete a screening for a patient who has no recent services or who does not have any services scheduled.

Are signatures required on the application?

- There is one signature line for the household on the application tab. That "signature" may be collected via email, patient portal, or phone call, and there is a line on the application for the facility to document if they are not able to get a wet signature. There are lines for signatures for the eligibility technician on each of the worksheets and the application. Both the household and the eligibility technician may sign the application electronically using a program like DocuSign that records the date and time of signing.

Is the application per event or per year?

- Screenings (or decline screening forms) are per episode of care unless the patient has a current determination
- Applications:
  - ➢One determination covers the household for a year unless the household requests to complete a redetermination
  - ➢A determination that results in a denial is only a denial for the dates of service the household is applying to cover

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Will there be an emergency version of the application?

- There is not an official emergency version of the application, but providers may set policies for patients to be screened and complete an application in an emergency situation that has fewer or different documentation requirements.

If a patient has services and screens over income, then loses their job and requests screening again, does that second screening apply to the date of service?

- In this situation, the patient would be able to apply for Hospital Discounted Care to cover the DOS since the screenings are preliminary and not official determinations. In the situation where the patient had completed an application and was found to be over income, they would not be able to complete a second application for the same DOS. A facility could choose to allow the second application if they wanted.

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Is there a “buy down” option like CICP?

- Since liquid resources are not included, there is not a “buy down” option for Hospital Discounted Care (and that option will go away for CICP as it is currently utilized). A facility could allow a patient to pay part of their medical bill and count that payment as a deduction in order to bring the household down under 250% FPG. Additionally, providers would be allowed to apply Hospital Discounted Care to patients above 250% FPG either by policy or on a case-by-case basis.

Do patients still need to provide a valid ID to apply? If the ID is expired, can we accept it?

- Patients have never been required to submit an ID for CICP, and that will not change with Hospital Discounted Care. Expired documentation, including IDs, are not acceptable.

What exists to ensure patient honesty and keep them from taking advantage of this system?

- Households must submit documentation of income to complete the application, so the provider will be able to determine what their income is

What would help a household decide between HDC and CICP?

- Households must provide all the same information for both HDC and CICP, except they must also provide their SSN (or sign a No SSN affidavit) and apply for public health care coverage programs if they appear eligible in order to qualify for CICP. Households are allowed to be on both HDC and CICP at the same time. Households will pay lower copays under CICP than for most HDC discounted services.

For file retention, do we need to separate the files for HDC vs CICP?

- You will not need to keep them separate, and it would be more or less impossible to do so since it is one application that covers both. Providers will need to be able to identify the patients who are CICP, HDC, or both for reporting and auditing purposes.

Determination Notice

Does written notification of determination need to be in their preferred language?

- Yes, the determination notifications must be provided in the household's preferred language.

Is the Department going to provide a template for the notice for facilities to use?

- The Department has not created a template, but all required elements are listed in the Operations Manual. Please note there are a few differences depending on if the household was determined eligible or ineligible after completing the application.

What happens if a household states they did not receive their notice, but their account is noted that one was sent?

- Facilities should be using the household's indicated preferred method of contact to send their determination notice. If the preferred method is by phone, written notification must also be sent. Notices sent through email or patient portal should have a date and time stamp for documentation.

Will there be a determination notice template, or will Providers need to create their own?

- There is not currently a Department created template, Providers should create their own following the mandated requirements listed in the Operations Manual.

Billing

If the patient completes the screening or signs the opt out, can the facility send bills before the 45- day mark?

- If a patient opts out, the provider may send a bill prior to the 45-day mark. If a patient completes a screening and decides to apply for Hospital Discounted Care, bills may not be sent prior to the application being completed and the determination notice being sent. If the patient decides not to apply, bills can be sent on the 46th day past the date of service or date of discharge, whichever is later.

Can we send informational bills that state they do owe anything at this time prior to the 46-day mark?

- Informational bills like this would be allowable as long as there is no amount due included, but facilities must ensure the information about the patient's rights and how to request a screening are included on the statement.

If a patient is in an accident and needs PT for a year afterwards, that is considered one episode of care and they will only be responsible for 36 payments?

- Yes, all of the physical therapy visits related to the original accident are considered part of the same episode of care, and therefore would fall under the payment plan set for the original accident and limited to no more than 4%/2% of the gross monthly household income for 36 payments.

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If a patient is at the hospital for multiple days, are we charging for inpatient rate for each day they stayed at the facility?

- The inpatient rate is per stay, not per diem.

Is an estimate for services considered a bill?

- An estimate for services is not considered a bill under Hospital Discounted Care. A billing statement is any patient facing communication, whether electronic or in writing, that specifies an amount due for services and instructions for making payment.

How should estimates be handled for patients?

- Patients who are scheduling services should be presented the Patient's Rights document and be screened if they are uninsured or if they are insured and request to be screened. If the patient is determined eligible, facilities should use the allowable bill rates on the estimate and explain the payment plan options. Patients who opt to pay in full prior to receiving services cannot be billed more than what their maximum payment plan would be at the full 4%/2% rate for 36 months.

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Payment Plans

Are the 4%/2% limits based off of gross household income?

- The limits are based on the final total income calculated on the household’s application. Depending on the facility’s policies, the final total income may include deductions from the household’s overall income.

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Is the limit 4% for every visit or 4% for all visits combined?

- Providers are allowed to set up new payment plans for patients for each new episode of care. Providers are reminded that this is a maximum and they are allowed to charge less per month or set up a shorter payment plan. Providers may also continue to use existing or new policies about limits on each payment plan, on a guarantor level, etc.

If a patient has surgery and then physical therapy, do we have to wait for the therapy visits to be over before we bill?

- Providers would be able to send a bill and set up a payment plan with these types of patients after the patient has received their determination. The additional physical therapy visits would be added to the account, but the initial payment plan would cover them all. For example, if the allowed billed amount for the surgery was $5000, the allowed billed amount for each therapy visit was $300, and the patient received 12 therapy visits over 12 weeks, the total allowed amount would increase by the $300 each week, but the payment plan total would stay the same.

Would we be allowed to write off the full amount of the patient's account and not set up a payment plan?

- It would be allowable under the Hospital Discounted Care rules to completely write off a patient's account. Providers would need to check with their own legal departments to ensure writing off the accounts would not be an issue under any other laws the provider must abide by.

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If we are billing for the facility and the physicians, is the limit 4% or 6%?

- The limit on a bill from a facility is 4% regardless of whether it includes physician services. If a licensed health care professional bills separately from the facility, their bill is subject to the 2% limit.

What if a patient has surgery, qualifies for HDC, the payment plan gets stablished for this episode. Three months later there is a different episode where screening the patient is found that he lost his job, has no income, and cannot afford to pay anything?

- In this situation, the patient shouldn't need to be screened again, as their determination should be valid for a year. Unless the job loss is very recent, the patient may have already contacted the facility to inform them of the job loss and their inability to make payments on their established payment plan. The patient has the right to ask to complete a new determination, and if a lower FPG is calculated, both their new and existing payment plans cannot exceed the 4%/2% limits.

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How does billing know what the household 4%/2% limits are?

- Providers will need to set up processes within their facilities and with any Licensed Health Care Professional on how communication of patient limits are communicated.

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If a patient wants to pay more than their 4%, can we accept the additional payment?

- Patients are allowed to pay more than their 4% max monthly amount towards their payment plan in order to pay off their balance early, Providers are just not allowed to bill them more than the 4% max.

If there are multiple episodes of care, does the 36 months reset during each episode of care?

- Payment plans for each episode of care cannot exceed 36 months of payments. If a payment plan is restructured to include additional episodes of care, Providers must ensure that the earlier episode(s) of care is completed within 36 months of the original payment plan being created.

What if a household skips a payment or makes a partial payment?

- Skipped and partial payments are allowed to be added on to the end of the payment plan. For example, let's say a patient called and said they had an unexpected expense and they were not going to be able to make the next two payments, which would have been payments 14 and 15. Those payments can be added onto the end of the plan as months 37 and 38, even though the payments are numbers 35 and 36. Similarly, let's say a patient's plan is set at $100 per month and they only pay $25. The remaining $75 gets added to the end of the payment plan in month 37 to complete the full 36 payments.

How many months can be skipped before the account is sent to collections?

- Providers may not send patients to collections until the third consecutive skipped month of payments, or 182 days past their date of discharge, whichever is later. Providers may send a letter after the second skipped payment notifying the household that the account may be sent to collections if another payment is missed. The letter must give the household an opportunity to report a change in household size or income and request a redetermination. The letter must be sent at least 30 days prior to collection actions being started.

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How many missed payments are patients allowed to have?

- Providers may send patients to collections after their third consecutive missed payment as long as it has been at least 181 days past their date of service or date of discharge, whichever is later.

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If a patient skips two payments, and on the third month sends in a payment to avoid collections, but then skips another two months then pays again on the third month, what can we do?

- Providers will need to consult with their legal teams in these situations to determine if the patient is following the established payment plan and whether they can be sent to collections.

How many partial payments are patients allowed to make?

- Providers will need to consult with their legal teams in these situations to determine if the patient is following the established payment plan and whether they can be sent to collections.

Do patients have to apply for HDC to get the 4%/2% payment plans?

- Patients must apply and comply with application requirements in order to be protected by the provisions of Hospital Discounted Care. If a patient declines to be screened or does not complete an application, they would fall under the provider's internal charity care program.

If a household qualifies for HDC but states they cannot afford the 4%, can we put them on our own internal charity care program?

- Patients who qualify for HDC are protected by the HDC rules. The 4%/2% and 36-month limits were put in place to help make health care more affordable for patients and encourage them to make the payments in exchange for a larger write off of their service charges. Some households still may not be able to afford 4%/2% for the payment plans. The Department encourages providers to work with these patients to set up plans that they will be able to afford and that will ensure the payment plan is completed.

How do payment plans work for insured patients?

- Insured households who qualify for Hospital Discounted Care will be responsible for the lower of:
  - The remainder of their bill after the insurance adjustment
  - The rates set by the Department
  - The 4%/2% of gross monthly household income for 36 months limits

Card

Will there be a HDC we can issue to qualified patients?

- The Uniform Application contains a template card that will fill in automatically when the eligibility technician is entering the household information into the application. Alternatively, the facility may create their own card as long as it contains all required information as listed in the Operations Manual.

Can patients have a CICP card and a HDC card?

- It is possible, especially during the first year of implementation, that a household may have two different cards. Patients who are screened for CICP at a CICP clinic may only have a CICP card, whereas patients screened at a non-CICP hospital may only have a Hospital Discounted Care card. It is also possible that a household could have two different Hospital Discounted Care cards if they have a determination completed at two different hospitals.

Can the patient use their card from one facility to another?

- Providers absolutely can accept determinations from other Providers via the patient's card or determination letter, or by contacting the other Provider. It is encouraged but not mandatory that Providers accept other Providers' determinations.

If a patient applies at a CICP facility and then goes to a hospital that doesn't accept CICP, would the hospital that doesn't offer CICP have to honor CICP determination?

- There will be no difference between a CICP rating and a Hospital Discounted Care determination, so there should not be an issue for the household moving between CICP and non-CICP hospitals. Any hospital can opt to complete their own determination if they find their deductions are different than the facility who completed the original determination.

Collections

For patients who opt out of the screening, does the collections process have to follow the HDC rules?

- Patients must apply and comply with application requirements in order to be protected by the provisions of Hospital Discounted Care. If a patient declines to be screened or does not complete an application, they would fall under the provider's internal collections processes. Reminder that an opt out is not final and the household can request to be screened at any point prior to their account being sent to collections.

Is sending a statement considered collections?

- No, sending a billing statement is not considered collections. Billing statements should not be sent prior to the patient completing their screening and/or application, but billing statements may be sent at the 46-day mark if the patient has not been screened, has not set up a screening appointment, and has not responded to the facility's contact attempts.

Is certain wording required on the notice that the patient might be sent to collections? Will that wording be provided?

- Per the bill, providers must send the patient "a plain language explanation of the health care services and fees being billed and notify the patient of potential collection actions."
- Since each notification will be unique to the patient, the Department will not be providing this wording.

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Reporting

Does the reporting starting in 2023 cover only 2023 or will it look back into 2022?

- The reporting will begin in 2023, and will cover from the implementation date of September 1, 2022. Most likely the first set of data will cover September 1, 2022 through June 30, 2023, and then all following reports will be on a state fiscal year (July 1 – June 30).

What is a “unique patient”?

- Each individual who is provided services at the facility is considered a unique patient. A unique patient may have multiple visits at the health care facility, but they are still just one person. The data will ask for how many individual patients were provided care as well as how many visits and admissions were associated with those patients.

Will the Department provide a reporting template?

- Yes, a template will be developed for providers to use to report their data related to Hospital Discounted Care.

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If a patient is referred out for Health First Colorado, where would they fall in the reporting?

- If a patient is screened and appears eligible for Health First Colorado, they would count as a unique patient under the screening section.

If we write off 100% for all qualified patients, would we just need to report the write offs?

- Facilities who write off all qualified patient accounts would still need to report on all of the other relevant areas, not just the write off information.

Will CICP reports be separate from HDC reports?

- The Department has no plans to combine these reports at this time, so providers should assume that separate reporting will be required for both CICP and Hospital Discounted Care.

Rates

Colorado has set EAPG rates. Will the HDC rates be the same as the EAPG rates or something other than that?

- Hospital Discounted Care rates are set at the higher of the Medicare or Medicaid rate.

How are services that do not have a Medicare or Medicaid rate handled? (e.g., elective, experimental)

- Providers must ensure that all services being discounted under Hospital Discounted Care are medically necessary. All medically necessary services should have a Medicaid rate. If a Provider finds that a medically necessary service does not have an associated Hospital Discounted Care rate, please contact the hcpf_HospDiscountCare@state.co.us inbox.

What happens if the rates defined by the state are higher than what the facility already charges?

- The rates under Hospital Discounted Care are maximums, and providers are allowed and encouraged to bill patients for less.

Questions?

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Thank you!