

8.900 COLORADO INDIGENT CARE PROGRAM (CICP)

PROGRAM OVERVIEW AND LEGAL BASIS

The Colorado Indigent Care Program (CICP) is a program that distributes federal and State funds to partially compensate Qualified Health Care Providers for uncompensated costs associated with services rendered to ~~the indigent-uninsured or underinsured population~~patients. Qualified Health Care Providers who receive this funding render discounted health care services to Colorado residents, migrant workers and ~~legal-lawfully present~~immigrants with limited financial resources who are uninsured or underinsured and not eligible for benefits under the Medicaid Program or the Children's Basic Health Plan.

The Colorado Department of Health Care Policy and Financing (Department) administers the CICP by distributing funding to Qualified Health Care Providers who serve eligible persons ~~who are indigent~~. The CICP issues procedures to ensure the funding is used to serve the ~~indigent-uninsured and underinsured~~population in a uniform method. Any significant departure from these procedures will result in termination of the approval of, and the funding to, a health care provider. The CICP is authorized by state law at part 1 of article 3 of title 25.5, C.R.S. (~~2016~~2020).

The CICP does not offer a specified discounted medical benefit package or an entitlement to medical benefits or funding to individuals or medical providers. The CICP does not offer a health coverage plan as defined in Section 10-16-102 (34), C.R.S. ~~Medically indigent persons~~Eligible persons receiving discounted health care services from Qualified Health Care Providers are subject to the limitations and requirements imposed by part 1 of article 3 of title 25.5, C.R.S.

8.901 DEFINITIONS

- A. Applicant means an individual who has applied at a Qualified Health Care Provider to receive discounted health care services.
- B. Children's Basic Health Plan or the Child Health Plan Plus (CHP+) means the Children's Basic Health Plan as defined in article 8 of title 25.5, C.R.S. (~~2016~~).
- C. Client means an individual whose application to receive discounted health care services has been approved by a Qualified Health Care Provider.
- D. Clinic Provider means any Qualified Health Care Provider that is a community health clinic licensed or certified by the Department of Public Health and Environment pursuant to C.R.S §25-1.5-103, a federally qualified health center as defined in 42 U.S.C. 1395x (aa)(4), or a rural health clinic, as defined in 42 U.S.C. 1395x (aa)(2).
- E. Colorado Indigent Care Program or CICP or Program means the Colorado Indigent Care Program as authorized by state law at part 1 of article 3 of title 25.5, C.R.S. (~~2016~~).
- F. Denver Metropolitan Area means the Denver-Aurora-Lakewood, CO metropolitan area as defined by the Bureau of Labor Statistics.
- G. Department means the Department of Health Care Policy and Financing established pursuant to title 25.5, C.R.S. (~~2016~~).
- H. Emergency Care means treatment for conditions of an acute, severe nature which are life, limb, or disability threats requiring immediate attention, where any delay in treatment would, in the judgment of the responsible physician, threaten life or loss of function of a patient or viable fetus.

- I. General Provider means a general hospital, birth center, or community health clinic licensed or certified by the Department of Public Health and Environment pursuant to Section 25-1.5-103(1)(a)(I) or (1)(a)(II), C.R.S., a federally qualified health center, as defined in 42 U.S.C. 1395x (aa)(4), a rural health clinic, as defined in 42 U.S.C. 1395x (aa)(2), a health maintenance organization issued a certificate authority pursuant to Section 10-16-402, C.R.S., and the University of Colorado Health Sciences Center when acting pursuant to Section 25.5-3-108 (5)(a)(I) or (5)(a)(II)(A), C.R.S. For the purposes of the Program, General Provider includes associated physicians.

42 U.S.C. 1395x is incorporated by reference. Such incorporation, however, excludes later amendments to or editions of the referenced material. Pursuant to Section 24-4-103(12.5), C.R.S., the Department of Health Care Policy and Financing maintains either electronic or written copies of the incorporated texts for public inspection. Copies may be obtained at a reasonable cost or examined during regular business hours at 1570 Grant Street, Denver, Colorado 80203. Additionally, any incorporated material in these rules may be examined at any State publications depository library.

- J. Homeless means a person who lacks a fixed, regular, and adequate night-time residence or has a primary night time residency that is: (A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations, (B) an institution that provides a temporary residence for individuals intended to be institutionalized, or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings. This does not include an individual imprisoned or otherwise detained pursuant to federal or state law.

- K. Hospital Provider means any Qualified Health Care Provider that is a general hospital licensed or certified by the Department of Public Health and Environment pursuant to Section 25-1.5-103, C.R.S. and which operates inpatient facilities.

- L. Liquid Resources means resources that can be readily converted to cash, including but not limited to checking and savings accounts, health savings accounts, prepaid bank cards, certificates of deposit less the penalty for early withdrawal.

- M. Medicaid means the Colorado medical assistance program as defined in article 4 of title 25.5, C.R.S.

- N. Qualified Health Care Provider means any General Provider who is approved by the Department to provide, and receive funding for, discounted health care services under the Colorado Indigent Care Program.

- O. Spend Down means when an Applicant uses his or her available Liquid Resources to pay off part or all of a medical bill to lower his or her financial determination to a level that will allow him or her to qualify for the Program.

- P. Transitional housing is housing designed to provide homeless individuals and families with the interim stability and support to successfully move to and maintain permanent housing.

- Q. Urgent Care means treatment needed because of an injury or serious illness that requires immediate treatment within 48 hours.

8.902 PROVISIONS APPLICABLE TO QUALIFIED HEALTH CARE PROVIDERS

- A. Requirements for Qualified Health Care Providers

1. Agreements will be made annually between the Department and Qualified Health Care Providers through an application process.

2. Agreements may be executed with Hospital Providers throughout Colorado that meet the following requirements:

- a. Licensed or certified as a general hospital or birth center by the Department of Public Health and Environment.
- b. Hospital Providers shall ~~assure that~~provide Emergency Care ~~is available~~ to all Clients throughout the Program year at discounted rates.
- c. Hospital Providers shall have at least two obstetricians with staff privileges at the Hospital Provider who agree to provide obstetric services to individuals under Medicaid. In the case where a Hospital Provider is located in a rural area (that is, an area outside of a metropolitan statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the Hospital Provider to perform non-emergency obstetric procedures.

This requirement does not apply to a Hospital Provider in which the inpatients are predominantly under 18 years of age or which does not offer non-emergency obstetric services as of December 21, 1987.

- d. Using the information submitted by an Applicant, the Qualified Health Care Provider shall determine whether the Applicant meets all requirements to receive discounted health care services under the Program. Eligibility shall be determined at the time of application, unless required documentation is not available, in which case the Applicant will be notified of the missing documentation within three business days. An eligibility determination should be made within three business days of receipt of the missing documents. If the Applicant is eligible to receive discounted health care services under the Program, the Qualified Health Care Provider shall determine an appropriate copayment for the Client. Hospital Providers shall determine if the Applicant is eligible to receive discounted services under the Program at the time of application, unless required documentation is not available, in which case a determination should be made within 15 working days of the date the Applicant provides a signed application and such other information, written or otherwise, as is necessary to process the application. Hospital Providers shall determine Client financial eligibility using the following information:

- I. Income from each Applicant age eighteen (18) and older;
- II. Household size, where all non-spouse or civil union partner, non-student adults ages eighteen (18) to sixty-four (64) included on the application must have financial support demonstrated or attested to; and
- III. Liquid Resources. Including Liquid Resources in the financial eligibility determination is optional for Hospital Providers. If a Hospital Provider chooses to include Liquid Resources in the financial eligibility determination, at least \$2,500 must be ~~protected-excluded~~ for each family member counted in household size, and the Hospital Provider must include a Spend Down opportunity.

- e. Hospital Providers shall submit a Sliding Fee Scale for Department approval with their annual application that shows copayments for different service categories divided into at least three income tiers covering 0 to 250% of the federal poverty level. Copayments shall be expressed in dollar amounts and shall not exceed the

copayments in the Standard Client Copayment Table found in Appendix A. [Hospital Providers shall inform Applicants and Clients of their copayment responsibilities at the time their application is approved.](#)

- f. Hospital Providers shall submit Program utilization and charge data in a format and timeline determined by the Department.
3. Agreements may be executed with Clinic Providers throughout Colorado that meet the following minimum criteria:
- a. Licensed or certified as a community health clinic by the Department of Public Health and Environment, or certified by the U.S. Department of Health and Human Services as a federally qualified health center or rural health clinic.
 - b. Using the information submitted by an Applicant, the provider shall determine whether the Applicant meets all requirements to receive discounted health care services under the Program. ~~Eligibility shall be determined at the time of application, unless required documentation is not available, in which case the Applicant will be notified of the missing documentation within three business days. An eligibility determination should be made within three business days of receipt of the missing documents. If the Applicant is eligible to receive discounted health care services under the Program, the Qualified Health Care Provider shall determine an appropriate copayment for the Client. Clinic Providers should determine if the Applicant is eligible to receive discounted services under the Program at the time of application, unless required documentation is not available, in which case a determination should be made within 15 days of the date the Applicant provides a signed application and such other information, written or otherwise, as is necessary to process the application.~~ Clinic Providers who are federally qualified health centers shall determine Client financial eligibility as required under federal regulations and guidelines. Clinic Providers who are not federally qualified health centers shall determine Client financial eligibility using the following information:
 - I. Income from each Applicant age eighteen (18) and older, and
 - II. Household size.
 - c. Clinic Providers shall submit a Sliding Fee Scale for Department approval with their annual application that shows copayments for different service categories. Copayments for Clients between 0 and 100% of the federal poverty level shall be nominal or \$0. Sliding Fee Scales shall have at least three tiers between 101 and 250% of the federal poverty level.
 - I. Sliding fee scales used by federally qualified health centers approved by the federal government meet all requirements of the Program.
 - II. Copayments for Clients between 101 and 250% of the federal poverty level may not be less than the copayments for Clients between 0 and 100% of the federal poverty level.
 - III. The same sliding fee scale shall be used for all Clients eligible for the Program.
 - IV. Sliding fee scales shall be reviewed by the Qualified Health Care Provider on a regular basis to ensure there are no barriers to care.

d. Clinic Providers shall inform Applicants and Clients of their copayment responsibilities at the time their application is approved.

ed. Clinic Providers shall submit Program data and quality metrics with their annual application. Specific quality metrics are listed in Section 8.905.B. The data and quality metrics shall be submitted in a format determined by the Department and provided as part of the annual application.

4. Determination of Lawful Presence

a. Qualified Health Care Providers shall develop procedures for handling original lawful presence documents to ensure that the documents are not lost, damaged or destroyed. Qualified Health Care Providers shall develop and follow procedures for returning or mailing original documents to Applicants within five business days of receipt.

b. Qualified Health Care Providers shall accept copies of an Applicant's lawful presence documentation that have been verified by other CACP providers, Medical Assistance sites, county departments of social services, or any other entity designated by the Department of Health Care Policy and Financing through an agency letter, ~~provided that the verification identifies that the copy is from an original and that the individual who reviewed the document(s) signifies such by including their name, organization, address, telephone number and signature on the copy.~~

c. Qualified Health Care Providers shall retain photocopies of the Applicant's affidavit and lawful presence documentation.

~~d. Qualified Health Care Providers shall not discriminate against Applicants on the basis of race, national origin, gender, religion, age or disability. If an Applicant has a disability that limits the Applicant's ability to provide the required evidence of citizenship or lawful presence, the provider shall assist the individual to obtain the required evidence. Qualified Health Care Providers shall assist applicants who have a disability, are homeless, or who lack proficiency in English with obtaining documentation to establish citizenship or lawful presence.~~

I. Examples of reasonable assistance that may be expected include, but are not limited to, providing contact information for the appropriate agencies that issue required documents; explaining the documentation requirements and how the Applicant may provide the required documentation; or referring the Applicant to other agencies or organizations which may be able to provide assistance.

II. Examples of additional assistance that shall be provided to Applicants who are unable to comply with the documentation requirements due to physical or mental impairments or homelessness and who do not have a guardian or representative who can provide assistance include, but are not limited to, contacting any known family members who may have the required documentation; contacting any known health care providers who may have the required documentation; or contacting other social services agencies or organizations that are known to have provided assistance to the Applicant.

III. The Qualified Health Care Provider shall not be required to pay for the cost of obtaining required documentation.

IV. The Qualified Health Care Provider shall document its efforts of providing additional assistance to the Applicant and retain such documentation.

5. Qualified Health Care Providers shall provide the Applicant and/or representative a written notice of the provider's determination as to the Applicant's eligibility to receive discounted services under the Program. If eligibility to receive discounted health care services is granted by the Qualified Health Care Provider, the notice shall include the dates of when eligibility began and the Applicant's copay responsibilities. If eligibility to receive discounted health care services is denied, the notice shall include a brief, understandable plain language explanation of the reason(s) for the denial. Every notice of the Qualified Health Care Provider's decision, whether an approval or a denial, shall include an explanation of the Applicant's appeal rights found at Section 8.902.B in these regulations.
6. Qualified Health Care Providers shall screen all Applicants for eligibility for Medicaid and the Children's Basic Health Plan and refer Applicants to those programs if they appear eligible. The Qualified Health Care Provider shall refer Applicants to Colorado's health insurance marketplace for information about private health insurance.
7. Qualified Health Care Providers shall not discriminate against Applicants or Clients on the basis of based on race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, or disability.

B. Client Appeals

1. If an Applicant or Client feels that a financial determination or denial is in error, he or she shall only challenge the financial determination or denial by filing an appeal with the Qualified Health Care Provider who determined eligibility to receive discounted health care services under the CICIP pursuant to this Section 8.902. There is no appeal process available through the Office of Administrative Courts.

2. Instructions for Filing an Appeal

The Qualified Health Care Provider shall inform the Applicant or Client that he or she has the right to appeal the financial determination or denial if he or she is not satisfied with the Qualified Health Care Provider's decision.

~~If the Applicant or Client wishes to appeal the financial determination or denial of the application, the Applicant or Client shall submit a written request for appeal to the Qualified Health Care Provider, which includes any documentation supporting the reasons for the request.~~An Applicant or Client who wishes to appeal a denial must:

- a. Submit a letter requesting appeal within 15 ~~business~~working days of the receipt of the denial notice. Appeals submitted after the deadline may be denied for being submitted ~~untimely~~;
 - b. Enclose any supporting documentation;
 - c. If no denial notice is received, an appeal letter can be submitted within 30 ~~business~~ days of the date the application was complete;
 - d. The deadline for an appeal letter may be extended for good cause.
3. Appeals

- a. ~~An Applicant or Client may file an appeal if he or she wishes to challenge the accuracy of his or her initial financial determination.~~

~~A Client or Applicant shall have 15 calendar days to request an appeal from the date of the Qualified Health Care Provider's decision.~~

~~If the Qualified Health Care Provider receives the Applicant's or Client's appeal after the 15 working day deadline, the Qualified Health Care Provider shall notify the Applicant or Client in writing that the appeal was denied because it was not submitted timely. At the discretion of the Qualified Health Care Provider and for good cause shown, including a death in the Applicant's or Client's immediate family member, the Qualified Health Care Provider may review an appeal received after 15 working days.~~

~~An Applicant or Client can request an appeal for the following reasons:~~

- a. ~~The initial financial determination or denial was based on inaccurate information because the family member or representative was uninformed;~~
- b. ~~The Applicant or Client believes that the calculation is inaccurate for some other reason; or~~
- c. ~~Miscommunication between the Applicant or Client and the financial determination technician cause incomplete or inaccurate data to be recorded on the application.~~

b. ~~Each Qualified Health Care Provider shall must designate a manager to review appeals and supporting documentation. An appeal involves receiving a written request from the Applicant or Client, and reviewing the application completed by the financial determination technician, including all back-up documentation, to determine if the application to receive discounted health care services under the CIGP is accurate.~~

c. ~~If the manager finds that the initial financial determination or denial is not is found to be inaccurate, the designated manager shall correct~~

I. ~~the financial determination will be corrected, with eligibility to receive discounted health care services under the CIGP and assign the correct financial determination to the Applicant or Client. The correct financial determination is effective retroactive to the initial date of application, and~~

II. ~~services provided during the applicable backdating period charges incurred 90 days prior to the initial date of application must be discounted.~~

d. ~~The Qualified Health Care Provider shall notifyA decision shall be issued to the Applicant or Client in writing of the results of an appeal within 15 businessworking days following receipt of the appeal request from the Applicant or Client.~~

4. Provider Management Exception

- a. ~~An Applicant or Client may request a provider management exception simultaneously with an appeal, or within 15 businessworking days of the Qualified Health Provider's decision regarding an appeal.~~

b. A provider management exception may be granted at the Qualified Health Care Provider's discretion if the Applicant or Client can demonstrate that there are circumstances that should be taken into consideration when establishing the household financial status.

c. Each Qualified Health Care Provider shall must designate a manager to review provider management exceptions and supporting documents.

I. The facility shall notify the Client in writing of the Qualified Health Care Provider's findings within 15 businessworking days of receipt of the written request.

II. The Qualified Health Care Provider must note provider management exceptions on the application.

~~At the discretion of the Qualified Health Care Provider and for good cause shown, the designated manager may grant the Applicant or Client a provider management exception to the Client's financial determination. This process can be used during the initial financial determination, simultaneously with an appeal, or within 15 working days of the Qualified Health Care Provider's decision regarding an appeal.~~

~~A Client may request and a Qualified Health Care Provider may grant a provider management exception if the Client can demonstrate that there are circumstances that should be taken into consideration when establishing his or her initial financial determination. Provider Management Exceptions shall always result in a lower Client financial determination.~~

~~A Client may request a provider management exception simultaneously with an appeal, or within 15 working days of the Qualified Health Care Provider's decision regarding an appeal.~~

~~The facility shall notify the Client in writing of the Qualified Health Care Provider's findings within 15 working days of receipt of the written request.~~

~~The Qualified Health Care Provider must note provider management exceptions on the application. Qualified Health Care Providers shall treat Clients equitably in the provider management exception process.~~

d. A financial determination from a provider management exception is effective as of the initial date of application.

~~Charges incurred 90 days prior to the initial date of application must be discounted.~~

~~Qualified Health Care Providers are not required to honor provider management exceptions granted by other Qualified Health Care Providers.~~

e. _____

C. Financial Eligibility

General Rule: An Applicant shall be financially eligible for discounted health care services under the CICIP if his or her household income is no more than 250% of the most recently published federal poverty level (FPL) for a household of that size.

1. Qualified Health Care Providers determine eligibility for the CICIP and shall maintain auditable files of applications for discounted health care services under the CICIP.

2. The determination of financial eligibility process looks at the financial circumstances of a household as of the date that an ~~signed~~ application is ~~started~~~~completed~~. In the event that an applicant is applying to cover a past individual visit or admission, or a string of visits, admissions, or both that occurred in a short amount of time, and is either not going to be applying for CICIP going forward or the date(s) of service are outside of the normal 90 day backdating window, the household financial status is considered as of the date of service instead of the date of the application.
3. All Qualified Health Care Providers must accept each other's CICIP financial determinations unless the Qualified Health Care Provider believes that the financial determination was determined incorrectly, the Qualified Health Care Provider's financial determination process is materially different from the process used by the issuing Qualified Health Care Provider, or that the financial determination was a result of a provider management exception.
4. CICIP eligibility is retroactive for services received from a Qualified Health Care Provider up to 90 days prior to application.
5. Documentation concerning the Applicant's financial status shall be maintained by the provider.
6. Beyond the distribution of available funds made by the CICIP, allowable Client copayments, and other third-party sources, a provider shall not seek payment from a Client for the provider's CICIP discounted health care services to the Client.
7. Emergency Application for Providers
 - a. In emergency circumstances, an Applicant may be unable to provide all of the information or documentation required by the usual application process. For emergency situations, the Qualified Health Care Provider shall follow these steps in processing the application:
 - I. Use the regular application to receive discounted health care services under the CICIP, but indicate emergency application on the application.
 - II. Ask the Applicant to give spoken answers to all questions and determine a federal poverty level based on the spoken information provided. If the Applicant appears eligible for Medicaid or CHP+, the Applicant will need to apply for the applicable program prior to being placed on CICIP. ~~to sign the application to receive discounted health care services under the CICIP.~~
 - III. Determine a federal poverty level based on the spoken information provided. Ask the Applicant to sign the application indicating their understanding of their federal poverty level and eligibility determination made using their spoken information.
 - b. An emergency application is good for only one episode of service in an emergency room and any subsequent service related to the emergency room episode. If the Client receives any care other than the emergency room visit, the Hospital Provider must request the Client to submit documentation to support all figures on the emergency application or complete a new application. If the documentation submitted by the Client does not support the earlier, spoken information, the Hospital Provider must obtain a new application from the Client. If the Client does not submit any supporting documentation or complete a new

application upon the request of the provider, the provider shall use the information contained in the emergency application.

- c. In emergency circumstances, an Applicant is not required to provide identification or execute an affidavit as specified at 10 C.C.R. 2505-10, Section 8.904.D.

D. Audit Requirements

The Department will conduct audits of Qualified Health Care Providers. Qualified Health Care Providers shall comply with requests for data and other information from the Department. Qualified Health Care Providers shall complete corrective actions when required by the Department. The Department's intention is to audit ~~at minimum one-sixth of the participating Qualified Health Care Providers in state fiscal year 2018-19 and at minimum one-third of the participating Qualified Health Care Providers each year beginning in state fiscal year 2019-20.~~

E. HIPAA

The CICIP does not meet the definition of a covered entity or business associate under the Health Insurance Portability and Accountability Act of 1996 at 45 CFR 160.103. The CICIP is not a part of the Colorado Medical Assistance Program, nor of Health First Colorado, Colorado's Medicaid program. CICIP's principal activity is the making of grants to providers who serve eligible persons who are ~~medically indigent~~uninsured or underinsured. The state personnel administering the CICIP will provide oversight in the form of procedures and conditions to ensure funds provided are being used to serve the target population, but they will not be significantly involved in any health care decisions or disputes involving a Qualified Health Care Provider or Client.

8.903 DISCOUNTED HEALTH CARE SERVICES

- A. Funding provided under the CICIP shall be used to provide Clients with discounted health care services determined to be medically necessary by the Qualified Health Care Provider.
- B. All health care services normally provided at the Qualified Health Care Provider should be available at a discount to Clients. If health care services normally provided at the Qualified Health Care Provider are not available to Clients at a discount, Clients must be informed that the services can be offered without a discount prior to the rendering of such services. Service availability is to be applied uniformly for all Clients.
- C. Qualified Health Care Providers receiving funding under the CICIP shall prioritize the use of funding such that discounted health care services are available in the following order:
 - 1. Emergency Care;
 - 2. Urgent Care; and
 - 3. Any other medical care.
- D. Additional discounted health care services may include:
 - 1. Emergency mental health services if the Qualified Health Care Provider renders these services to a Client at the same time that the Client receives other medically necessary services.
 - 2. Qualified Health Care Providers may provide discounted pharmaceutical services. The Qualified Health Care Provider should only provide discounted prescriptions that are written by doctors on its staff, or by a doctor that is under contract with the Qualified

Health Care Provider. Qualified Health Care Providers shall exclude prescription drugs included in the definition of Medicare Part-D from eligible Clients who are also eligible for Medicare.

3. Qualified Health Care Providers may provide packages of services to patients with modified copayment requirements.
 - a. Packages of services benefit Clients who need to utilize services more often than average Clients. Things that would be beneficial to the client include but are not limited to charging a lower copay, charging the copay on an alternative schedule (i.e. once a week, or ever other time), or setting a cap on the amount or number of copayments made towards the packaged services. Examples of packages may include but are not limited to oncology treatments, physical therapy, and dialysis.
 - b. Qualified Health Care Providers may provide a prenatal benefit with a predetermined copayment designed to encourage access to prenatal care for [indigent-uninsured or underinsured](#) women. This prenatal benefit shall not cover the delivery or the hospital stay, or visits that are not related to the pregnancy. The Qualified Health Care Provider is responsible for providing a description of the services included in the prenatal benefit to the Client prior to services rendered. Services and copayments may vary among sites.

E. Excluded Discounted Health Care Services

Funding provided under the CICIP shall not be used for providing discounted health care services for the following:

1. Non-urgent dental services.
2. Nursing home care.
3. Chiropractic services.
- ~~4. Sex change surgical procedures.~~
- ~~54.~~ Cosmetic surgery.
- ~~65.~~ Experimental and non-United States Federal Drug Administration approved treatments.
- ~~76.~~ Elective surgeries that are not medically necessary.
- ~~87.~~ Court ordered procedures, such as drug testing.
- ~~98.~~ Abortions - Except as specified in Section 25.5-3-106, C.R.S.
- ~~109.~~ Mental health services in clinic settings pursuant to Section 25.5-3-110, C.R.S., part 2 of article 66 of title 27, C.R.S., any provisions of article 22 of title 23, C.R.S., or any other provisions of law relating to the University of Colorado Psychiatric Hospital.

8.904 PROVISIONS APPLICABLE TO CLIENTS

A. Overview of Requirements

In order to qualify to receive discounted health care services under available CICIP funds, an Applicant shall satisfy the following requirements:

1. Execute an affidavit regarding citizenship status;
2. Be lawfully present in the United States;
3. Be a resident of Colorado;
4. Meet all CICIP eligibility requirements as defined by state law and procedures; and
5. Furnish a social security number (SSN) or evidence that an application for a SSN has been submitted, where required by 10 C.C.R. 2505-10, Section 8.904.G (2016) or meet one of the following exceptions:
 - a. individual is an unborn child;
 - b. individual is homeless and unable to provide a SSN;
 - c. individual is ineligible for a SSN;
 - d. individual may only be issued a SSN for a valid non-work reason in accordance with 20 CFR 422.104;
 - e. individual refuses to obtain a SSN because of well-established religious objections.

B. Applicants

1. Any adult age 18 and older may apply to receive discounted health care services on behalf of themselves and members of the Applicant's family household.
2. If an Applicant is deceased, the executor of the estate or a family member may complete the application on behalf of the Applicant. The family member completing the application will not be responsible for any copayments incurred on behalf of the deceased member.
3. The application to receive discounted health care services under available CICIP funding shall include the names of all members of the Applicant's family household. All non-spouse or civil union partner, non-student adults ages 18-64 must have financial support demonstrated or attested to in order to be included in household size. All minors and those 65 or older do not need documentation of financial support to be counted in household size. Income from spouses or civil union partners and all non-student adults must be included in the application.
4. A minor shall not be rated separately from his or her parents or guardians unless he or she is emancipated or there exists a special circumstance. A minor is an individual under the age of 18.

C. Signing the Application

The Applicant or an authorized representative of the Applicant must sign the application to receive discounted health care services submitted to the Qualified Health Care Provider within 90 calendar days of the date of health care services. If an Applicant is unable to sign the application or has died, a spouse, civil union partner, relative, or guardian may sign the application. Until it is signed, the application is not complete, the Applicant cannot receive discounted health care

services under the CICP, and the Applicant has no appeal rights. All information needed by the provider to process the application must be submitted before the application is signed.

D. Affidavit

1. Each first-time Applicant, or Applicant seeking to reapply, eighteen (18) years of age or older shall execute an affidavit stating:
 - a. That he or she is a United States citizen, or
 - b. That he or she is a legal permanent resident, or is otherwise lawfully present in the United States pursuant to [federal law 1 CCR 204-30 Rule 5](#).
2. For an Applicant who has executed an affidavit stating that he or she is lawfully present in the United States but is not a United States citizen, the provider shall ~~within 30 days of the application date,~~ verify lawful presence through the Federal Systematic Alien Verification ~~for~~ Entitlements (SAVE) Program operated by the United States Department of Homeland Security or a successor program designated by the United States Department of Homeland Security [within three business days of receipt of the lawful presence documentation. A SAVE verification is not needed for Applicants who provide an ID issued by a REAL ID Act compliant state that bears the REAL ID Act indicator. Until verification of lawful presence is made, the affidavit may be presumed to be proof of lawful presence.](#)

E. Establishing Lawful Presence

1. Each first-time Applicant, or Applicant seeking to reapply, eighteen (18) years of age or older shall be considered lawfully present in the country if they produce a document or waiver in accordance with 1 CCR 204-30 Rule 5 (effective ~~August 30, 2016~~ [September 17, 2020](#)), which is hereby incorporated by reference. This incorporation of 1 CCR 204-30 Rule 5 excludes later amendments to, or editions of, the referenced material. Pursuant to Section 24-4-103 (12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.
2. Submission of Documentation
Lawful presence documentation may be accepted from the Applicant, the Applicant's spouse, civil union partner, parent, guardian, or authorized representative in person, by mail, [by email](#), or facsimile.
3. Expired or absent documentation for non-U.S. citizens
 - a. If an Applicant ~~presents expired documents or~~ is unable to present any documentation evidencing his or her immigration status, refer the Applicant to the local Department of Homeland Security office to obtain documentation of status.
 - b. In unusual circumstances involving Applicants who are hospitalized or medically disabled or who can otherwise show good cause for their inability to present documentation and for whom securing such documentation would constitute undue hardship, if the Applicant can provide an alien registration number, the provider may file U.S.C.I.S. Form G-845 and Supplement, along with the alien

registration and a copy of any expired Department of Homeland Security document, with the local Department of Homeland Security office to verify status.

- c. If an Applicant does not present documentation proving their lawful presence but instead presents a receipt indicating that he or she has applied to the Department of Homeland Security for a replacement document, file U.S.C.I.S. Form G-845 and Supplement with a copy of the receipt with the local Department of Homeland Security office to verify status.

F. Residence in Colorado

An Applicant must be a resident of Colorado. A Colorado resident is a person who currently lives in Colorado and intends to remain in the state.

Migrant workers and all dependent family members must meet all of the following criteria to comply with residency requirements:

1. Maintains a temporary home in Colorado for employment reasons;
2. Meet the lawful presence criteria, as defined in paragraph E of this Section; and
3. Employed in Colorado.

~~G. Except in the circumstances enumerated below, social security number(s) shall be required for all Clients receiving discounted health care services under the Program. If an Applicant does not have a social security number, documentation that the Applicant has applied for a social security number must be provided to complete the application to receive discounted health care services under the Program. This section shall not apply to unborn children, homeless individuals who are unable to provide a social security number, individuals who are not eligible to receive a social security number, individuals who may only be issued a social security number for a valid non-work reason in accordance with 20 CFR 422.104, or individuals who refuse to obtain a social security number because of well-established religious objections.~~

H.G. Applicants Not Eligible

1. The following individuals are not eligible to receive discounted services under the CICIP:
 - a. Individuals for whom lawful presence cannot be verified.
 - b. Individuals who are being held or confined involuntarily under governmental control in State or federal prisons, jails, detention facilities or other penal facilities. This includes those individuals residing in detention centers awaiting trial, at a wilderness camp, residing in half-way houses who do not have freedom of movement and association, and those persons in the custody of a law enforcement agency temporarily released for the sole purpose of receiving health care.
 - c. College students whose residence is from outside Colorado or the United States that are in Colorado for the purpose of higher education. These students are not Colorado residents and cannot receive services under the CICIP.
 - d. Visitors from other states or countries temporarily visiting Colorado and have primary residences outside of Colorado.

- e. Persons who qualify for Medicaid. However, Applicants whose only Medicaid benefits are the following shall not be excluded from consideration for CICP eligibility:
 - I. QMB benefits described at Section 10 C.C.R. 2505-10, Section 8.100.6.L (2016) of these regulations;
 - II. SLMB benefits described at Section 10 C.C.R. 2505-10, Section 8.1006.M (2016), or
 - III. The QI1 benefits described at Section 10 C.C.R. 2505-10, Section 8.100.6.N (2016).
- f. Individuals who are eligible for the Children's Basic Health Plan.

H. Health Insurance Information

The Applicant shall submit all necessary information related to health insurance, including a copy of the insurance policy or insurance card, the address where the medical claim forms must be submitted, policy number, and any other information determined necessary.

J. Subsequent Insurance Payments

If a Client receives discounted health care services under the CICP, and their insurance subsequently pays for services, or if the Client is awarded a settlement, the insurance company or patient shall reimburse the Qualified Health Care Provider for discounted health care services rendered to the Client.

8.905 DEPARTMENT RESPONSIBILITIES

A. Provider Application

1. The Department shall produce and publish a provider application annually.
 - a. The application will be updated annually to incorporate any necessary changes and update any Program information.
 - b. The application will include data and quality metric submission templates.
2. The Department shall determine Qualified Health Care Providers annually through the application process.
3. An agreement will be executed between the Department and Denver Health for the purpose of providing discounted health care services to the residents of the City and County of Denver, as required by Section 25.5-3-108 (5)(a)(I), C.R.S.
4. An agreement will be executed between the Department and University Hospital for the purpose of providing discounted health care services in the Denver Metropolitan Area and complex care that is not contracted for in the remaining areas of the state, as required by Section 25.5-3-108 (5)(a)(II), C.R.S.
5. The Department shall produce and publish a provider directory annually.

B. Payments to Providers

1. Funding for hospitals shall be distributed in accordance with 10 CCR 2505-10 Section 8.3000 and 8.905 B.3.
2. Clinics
 - a. Funding for Clinic Providers is appropriated through the Colorado General Assembly under the Children's Hospital, Clinic Based Indigent Care line item. Effective July 1, 2018, funding for clinics shall be separated into two different groups, as follows:
 - I. Seventy-five (75) percent of the funding will be distributed based on Clinic Providers' write off costs relative to the total write off costs for all Clinic Providers.
 - II. Twenty-five (25) percent of the funding will be distributed based on a points system granted to Clinic Providers based on their quality metric scores multiplied by the Clinic Provider's total visits from their submitted Program data.
 - b. The quality metric scores will be calculated based on the following four metrics. The metrics are defined by the Health Resources & Services Administration (HRSA):
 - I. Preventative Care and Screening: Body Mass Index (BMI) Screening and Follow Up
 - II. Preventative Care and Screening: Screening for Clinical Depression and Follow-up Plan
 - III. Diabetes: Hemoglobin A1c Poor Control
 - IV. Controlling High Blood Pressure
 - c. Write off costs will be calculated as follows:
 - I. Distribution of available funds for [indigent-CICP](#) care costs will be calculated based upon historical data. Third-party liabilities and the patient liabilities will be deducted from total charges to generate [medically indigent-CICP](#) charges.
 - II. Clinic Providers shall deduct amounts due from third-party payment sources from total charges declared on the summary statistics submitted to the Department.
 - III. Clinic Providers shall deduct the full patient liability amount from total charges, which is the amount due from the Client as identified in the CICP Standard Client Copayment Table, as defined under Appendix A in these rules, or an alternative sliding fee scale that is submitted by the provider with the annual application for the CICP and approved by the Department. The summary information submitted to the Department by the provider shall include the full CICP patient liability amount even if the Clinic Provider receives the full payment at a later date or through several smaller installments or no payment from the Client.

IV. ~~Medically indigentCICP~~ charges will be converted to ~~medically indigentCICP~~ costs using the most recently available cost-to-charge ratio from the Clinic Provider's cost report or other financial documentation accepted by the Department.

d. The Department shall notify Clinic Providers of their expected payment no later than August 31 of each year. The notification shall include the total expected payment and a description of the methodology used to calculate the payment.

~~e. For the 2017-18 Program year, Clinic Provider payments will be based solely on calendar year 2016 write-off costs relative to the total write-off costs for all Clinic Providers. Write-off charges shall be calculated as described in part c of this section.~~

3. Pediatric Major Teaching Hospital Payment. Hospital Providers shall qualify for additional payment when they meet the criteria for being a major teaching hospital provider and when their Medicaid-eligible inpatient days combined with ~~indigent-CICP~~ care days (days of care provided under the Colorado Indigent Care Program) equal or exceed 30 percent of their total inpatient days for the most recent year for which data are available. A major teaching hospital provider is defined as a Colorado hospital, which meets the following criteria:

a. Maintains a minimum of 110 total Intern and Resident (I/R) F.T.E.'s;

b. Maintains a minimum ratio of .30 Intern and Resident (I/R) F.T.E.'s per licensed bed;

c. Qualifies as a Pediatric Specialty Hospital under the Medicaid Program, such that the hospital provides care exclusively to pediatric populations.

d. Has a percentage of Medicaid-eligible inpatient days relative to total inpatient days that equal or exceeds one standard deviation above the mean; and

e. Participates in the Colorado Indigent Care Program

The Major Teaching Hospital Rate is set by the Department such that the payment will not exceed the appropriation set by the General Assembly.

C. Provider Appeals

1. Any provider who submits an application to become a Qualified Health Care Provider whose application is denied may appeal the denial to the Department.

2. The provider's first level appeal must be filed within five (5) business days of the receipt of the denial letter. The Department's Special Financing Division Director will respond to any first level appeals within ten (10) business days of receipt of the appeal.

3. If a provider disagrees with the Department's Special Financing Division Director's first level appeal determination, they may file a second level appeal within five (5) business days of the receipt of the first level appeal determination. The Department's Executive Director will respond to the second level appeal within ten (10) business days of the receipt of the second level appeal.

D. Advisory Council

The Department shall create a CICIP Stakeholder Advisory Council, effective July 1, 2017. The Executive Director of the Department shall appoint 11 members to the CICIP Stakeholder Advisory Council. Members shall include:

1. A member representing the Department;
2. Three consumers who are eligible for the Program or three representatives from a consumer advocate organization or a combination of each;
3. A representative from a federally qualified health center as defined at 42 U.S.C. 1395x (aa)(4);
4. A representative from a rural health clinic as defined at 42 U.S.C. 1395x (aa)(2), or a representative from a clinic licensed or certified as a community health clinic by the Department of Public Health and Environment, or a representative from an organization that represents clinics who are not federally qualified health centers;
5. A representative from either Denver Health or University Hospital;
6. A representative from an urban hospital;
7. A representative from a rural or critical access hospital;
8. A representative of an organization of Colorado community health centers, as defined in the federal "Public Health Service Act", 42 U.S.C. sec. 254b;
9. A representative from an organization of Colorado hospitals.

Members shall serve without compensation or reimbursement of expenses. The Executive Director shall at least annually select a chair for the council to serve for a maximum period of twelve months. The Department shall staff the council. The council shall convene at least twice every fiscal year according to a schedule set by the chair. Members of the council shall serve three-year terms. Of the members initially appointed to the advisory council, the executive director shall appoint six for two-year terms and five for three-year terms. In the event of a vacancy on the advisory council, the executive director shall appoint a successor to fill the unexpired portion of the term of such member.

The council shall

1. Advise the Department of operation and policies for the Program
2. Make recommendations to the Medical Services Board regarding rules for the Program

E. Annual Report

1. The Department shall prepare an annual report concerning the status of the Program to be submitted to the Health and Human Services committees of the Senate and House of Representatives, or any successor committees, no later than February 1 of each year.
2. The report shall at minimum include charges for each Qualified Health Care Provider, numbers of Clients served, and total payments made to each Qualified Health Care Provider.

10 CCR 2505-10 § 8.900 APPENDIX A: STANDARD CICIP CLIENT COPAYMENT

A. Client Copayments - General Policies

A Client is responsible for paying a portion of his or her medical bills. The Client's portion is called the Client Copayment. Qualified Health Care Providers are responsible for charging the Client a copayment. Qualified Health Care Providers may require Clients to pay their copayment prior to receiving care (except for Emergency Care). Qualified Health Care Providers may charge copayments in accordance with the Standard Client Copayment Table or an alternate sliding fee scale that is submitted by the provider with the annual application for the CICIP and approved by the Department.

Percent of FPL	0 - 40% and Homeless	0 - 40%	41 - 62%	63 - 81%	82 - 100%	101 - 117%	118 - 133%	134 - 159%	160 - 185%	186 - 200%	201 - 250%
Ambulatory Surgery	\$0	\$15	\$65	\$105	\$155	\$220	\$300	\$390	\$535	\$600	\$630
Inpatient Facility	\$0	\$15	\$65	\$105	\$155	\$220	\$300	\$390	\$535	\$600	\$630
Hospital Physician	\$0	\$7	\$35	\$55	\$80	\$110	\$150	\$195	\$270	\$300	\$315
Emergency Room	\$0	\$15	\$25	\$25	\$30	\$30	\$35	\$35	\$45	\$45	\$50
Emergency Transportation	\$0	\$15	\$25	\$25	\$30	\$30	\$35	\$35	\$45	\$45	\$50
Outpatient Hospital Services	\$0	\$7	\$15	\$15	\$20	\$20	\$25	\$25	\$35	\$35	\$40
Clinic Services	\$0	\$7	\$15	\$15	\$20	\$20	\$25	\$25	\$35	\$35	\$40
Specialty Outpatient	\$0	\$15	\$25	\$25	\$30	\$30	\$35	\$35	\$45	\$45	\$50
Prescription	\$0	\$5	\$10	\$10	\$15	\$15	\$20	\$20	\$30	\$30	\$35
Laboratory	\$0	\$5	\$10	\$10	\$15	\$15	\$20	\$20	\$30	\$30	\$35
Basic Radiology & Imaging	\$0	\$5	\$10	\$10	\$15	\$15	\$20	\$20	\$30	\$30	\$35
High-Level Radiology & Imaging	\$0	\$30	\$90	\$130	\$185	\$250	\$335	\$425	\$580	\$645	\$680

There are different copayments for different service charges. The following information explains the different types of medical care charges and the related Client Copayments under the Standard Client Copayment Table.

1. Inpatient facility charges are for all non-physician (facility) services received by a Client while receiving care in the hospital setting for a continuous stay of 24 hours or longer.
2. Ambulatory Surgery charges are for all non-physician (facility) Ambulatory Surgery operative procedures received by a Client who is admitted to and discharged from the hospital setting on the same day. The Client is also responsible for the corresponding Hospital Physician charges.
3. ~~The~~ Hospital Physician charges are for services provided directly by a physician in the hospital setting, including inpatient, ambulatory surgery, and emergency room care.
4. Clinic Services charges are for all non-physician (facility) and physician services received by a Client while receiving care in the outpatient clinic setting. Outpatient charges include primary and preventive medical care. This charge does not include radiology or laboratory services performed at the clinic.
5. Emergency Room charges are for all non-physician (facility) services received by a Client while receiving Emergency Care or Urgent Care in the hospital setting for a continuous stay less than 24 hours (i.e., emergency room care).
6. Specialty Outpatient charges are for all non-physician (facility) and physician services received by a Client while receiving care in the specialty outpatient setting. These services can be provided in standalone clinics and outpatient hospital settings. Specialty Outpatient charges include distinctive medical care (i.e., oncology, orthopedics, hematology, pulmonary) that is not normally available as primary and preventive medical care. Specialty Outpatient charges do not include radiology, laboratory, emergency room, or ambulatory surgery services provided in a hospital setting.
7. Emergency Transportation charges are for transportation provided by an ambulance.
8. Laboratory Service charges are for all laboratory tests received by a Client while receiving care in the outpatient hospital or clinic setting. Laboratory Service charges may not be charged in addition to charges for emergency room or inpatient services provided in the hospital setting.
9. Basic Radiology and Imaging Service charges are for all radiology and imaging services received by a Client while receiving care in the outpatient hospital or clinic setting. Basic Radiology and Imaging Service charges may not be charged in addition to charges for emergency room or inpatient services provided in the hospital setting.
10. Prescription charges are for prescription drugs received by a Client at a Qualified Health Care Provider's pharmacy as an outpatient service. To encourage the availability of discounted prescription drugs, providers are allowed to modify (increase or decrease) the Prescription Copayment with the written approval of the Department.
11. High-Level Radiology and Imaging Service charges are for Clients receiving a Magnetic Resonance Imaging (MRI), Computed Tomography (CT), Positron Emission Tomography (PET) or other Nuclear Medicine services, Sleep Studies, or Catheterization Laboratory (cath lab) in the outpatient hospital, emergency room, or clinic setting.

12. Outpatient Hospital Service charges are for all non-physician (facility) and physician services received by a Client while receiving non-Emergency Care or non-Urgent Care in the outpatient clinic setting. Outpatient Hospital Services charges include primary and preventive medical care. This charge does not include radiology, laboratory, emergency room, or ambulatory surgery services provided in a hospital setting.
13. Clients who are seen in the hospital setting in an observation bed should be charged the emergency room copay if their stay is less than 24 hours and the inpatient facility copay if their stay is 24 hours or longer.

B. Homeless Clients, Clients living in transitional housing, Clients residing with others, or recipients of Colorado's Aid to the Needy Disabled financial assistance program, who are at or below 40% of the Federal Poverty Level are exempt from Client Copayments.

1. ~~Homeless. A person is considered homeless who lacks a fixed, regular, and adequate night time residence or has a primary night time residency that is: (A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations, (B) an institution that provides a temporary residence for individuals intended to be institutionalized, or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings. This does not include an individual imprisoned or otherwise detained pursuant to federal or state law.~~

~~In addition,~~ homeless Clients are exempt from Client Copayments, the income verification requirement, and providing proof of residency when completing the CICIP application.

2. ~~Transitional Housing.~~ Transitional housing is designed to assist individuals in becoming self-supporting, ~~but not referenced in 8.904.E.2.~~ Clients living in transitional housing must provide a written statement from their counselor or program director asserting that they are participating in a transitional housing program. ~~†~~

~~In addition,~~ ~~†~~ Transitional housing Clients are exempt from the income verification requirement when completing the CICIP application.

3. ~~Residing with Others.~~ Clients who have no permanent housing of their own and who are temporarily living with a person who has no legal obligation to financially support the Client are considered residing with others. The individual allowing the Client to reside with him or her may be asked to provide a written statement confirming that the Client is not providing financial assistance to the household and that the living arrangement is not intended to be permanent.

4. ~~Recipient of Colorado's Aid to the Needy Disabled financial assistance program. A Client who is eligible and enrolled to receive the monthly grant award from Colorado's Aid to the Needy Disabled financial assistance program.~~

~~In addition,~~ ~~†~~ recipients of Colorado's Aid to the Needy Disabled financial assistance program are exempt from Client Copayments, and the income verification requirement when completing the CICIP application.

C. Client Annual Copayment Cap

1. Homeless Clients whose financial determination is between 0 and 40% of the federal poverty level are exempt from copayments, so their copayment cap is \$0. Clients whose financial determination is between 0 and 40% of the federal poverty level who are not homeless have a copayment cap that is the lesser of 10% of the family's net income or \$120. Clients who are also Old Age Pension Health and Medical Care Program clients

have a copayment cap of \$300 as mandated by 10 CCR 2505-10 8.941.10. For all other CICP Clients, annual copayments shall not exceed 10% of the family's financial determination.

2. Clients who are also Old Age Pension Health and Medical Care Program clients have annual copayment caps based on a calendar year. All other Client annual copayment caps (annual caps) are based on the Client's date of eligibility.
 3. Clients are responsible for any charges incurred prior to the determination of the Client's financial eligibility.
 4. Clients are responsible for tracking their CICP copayments and informing the provider in writing, including documentation, within 90 days after meeting or exceeding their annual cap. If a Client overpays the annual cap and informs the Qualified Health Care Provider of that fact in writing, the Qualified Health Care Provider shall reimburse the Client for the overpayment.
 5. A CICP Client is eligible to receive a new determination if his or her financial or family situation has changed since the initial financial determination. CICP copayments made under the prior financial determination will not count toward a new CICP copayment cap and the Client's annual copayment cap resets when the Client completes a new application.
 6. An annual cap applies only to charges incurred after a Client is eligible to receive discounted health care services, and applies only to discounted services incurred at a CICP Qualified Health Care Provider.
- D. The Client must pay the lower of the copayment listed, the patient responsibility portion if the Client is insured, or actual charges.
- E. Clients shall be notified at or before time of services rendered of their copayment responsibility.
- F. [Grants for Client Copayments](#)

Grants from foundations to Clients from non-profit, tax exempt, charitable foundations specifically for Client copayments are not considered other medical insurance or income. The provider shall honor these grants and may not count the grant as a resource or income.

8.930 [Repealed effective 8/12/2011.]