Final Proposal: CICP Program Future

May 23, 2022

Impetus

The Colorado Indigent Care Program (CICP) allows low-income Coloradans who are not eligible for Medicaid to receive discounted health care services on a sliding fee at participating hospitals and community health centers/safety net clinics. CICP was established in state law in 1983, to offer discounted health care services to low-income people. Hospitals and clinics can offer discounts to lawfully present patients with incomes up to 250% of the federal poverty guideline (FPG), and to participate must submit their sliding fee scale to the Department of Health Care Policy and Financing (the Department or HCPF) for approval. Patients must apply to the CICP program at the clinic or hospital.

The expansion of Medicaid in 2014 under the Affordable Care Act enabled many more people to become enrolled in Medicaid and lowered the number of Coloradans receiving discounted health care services through CICP from approximately 200,000 to 40,000 people per year.

CICP Hospitals are funded through the Disproportionate Share Hospital (DSH) payment that is part of the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE). CHASE charges a healthcare affordability and sustainability fee on hospitals which is matched with federal funds. The total funds collected are used to increase hospital reimbursement for services provided to Health First Colorado and CICP clients, fund hospital quality incentive payments, and finance health coverage expansion in the Health First Colorado and Child Health Plan *Plus* (CHP+) programs. Hospital payments financed with fees are reported on a federal fiscal year (FFY) basis. CHASE hospital payments for federal fiscal year (FFY) 2020-21 totaled more than $1.48 billion, including $219 million in DSH payments for CICP Hospitals.

CICP Clinics have historically been funded through general funds matched with federal funds, for a total of around $6 million annually.

Recent state legislation has changed CICP clinic funding and hospitals' financial assistance program requirements resulting in increased administrative burden for participating hospitals and clinics and reduced incentives for clinics to participate.

- Senate Bill (SB) 21-205 (Long Appropriations bill) eliminated the CICP clinic line item. This change was made in part because of SB 21-212 (Primary Care Payment Align Federal Funding) which directed HCPF to seek federal match for the Primary Care Fund (PCF), which is a separate source of clinic-funding to help partially cover the costs of caring for uninsured and underinsured patients. With these two changes, funding for

clinics to care for uninsured patients increased on the whole from $31 million ($6 million CICP and $25 million PCF) to $50 million per year (PCF only).

- House Bill (HB) 21-1198, also known as Hospital Discounted Care, requires all Colorado hospitals to screen low-income, uninsured patients for public health coverage program eligibility and to allow them to apply for financial assistance or charity care programs at the health care facility where they receive care. The bill limits service charges, limits payment plan amounts and duration, sets up patient appeal rights, and limits collection activities. Additionally, the bill required updating the CICP Rules to align with the rules for Hospital Discounted Care as closely as possible.

The Department is committed to preserving and improving Colorado's safety net for those who need it by reducing the administrative burden for patients and those providers who service uninsured, underinsured, and other patients with low-income in need of care.

Process

Colorado Code of Regulations, 10 CCR 2505-10-8.905.D, required the Department to create a Colorado Indigent Care Program (CICP) Stakeholder Advisory Council (Advisory Council), effective July 1, 2017. The Advisory Council advises the Department on the operation and policies for CICP and makes recommendations to the Medical Services Board regarding rules for CICP. Based on the impetus noted above, the Advisory Council:

1. Determined considerations for CICP's future, including maximizing access to high-quality services and minimizing the administrative burden associated with CICP in light of other changes
2. Developed options and evaluated the options versus criteria to create this draft proposal
3. Shared the draft proposal with stakeholders during the April 25, 2022 Advisory Council meeting to hear their feedback and offered the opportunity for additional feedback until May 12, 2022
4. Incorporated feedback and reviewed at the May 23, 2022 Advisory Council meeting and finalized the recommendations contained in this proposal

The Advisory Council remains committed to this process and engaging with the Department. The Department remains committed to engaging with the Advisory Council and keeping them informed of the process.

Note: The Advisory Council acknowledged that changes to income calculation, lawful presence requirements, and determination notification requirements will take effect regardless of these recommendations. Legislation in 2021 created Hospital Discounted Care and instructed the Department to align the rules for CICP as closely as possible with the new rules for Hospital Discounted Care. As a result, income calculation rules for CICP hospitals no longer allow for the inclusion of liquid resources and applicant household income calculations have been limited to include a specific list of income sources. Lawful presence will no longer be a requirement for CICP patients beginning July 1, 2022, as a result of SB 21-199.

Final Proposal

Below is a summary of the Advisory Council's proposal and rationale, followed by an analysis of pros and cons in terms of access and administrative burden from the point of view of hospitals, clinics, and patients.

Contribute to Continued Safety Net Services In Two Ways:

- **Clinics:** Primary Care Fund (PCF) dollars fund federally qualified health centers (FQHCs) and other clinics for services to low-income Coloradans making up to 200% of FPG
- **Hospitals:** Adjust Disproportionate Share Hospital (DSH) Rules (in the Medicaid State Plan) to reflect the current minimum requirements of CICP related to hospital charity care programs and allocate funding to hospitals providing services to Coloradans making up to 250% FPG

Recommend Ending CICP, which involves:

- Eliminating all CICP reporting requirements for clinics and hospitals
- Aligning State auditing requirements across Hospital Discounted Care and DSH to simplify hospital and Department processes (Federal DSH audit will remain the same)
- Encouraging hospitals to engage their community through the Hospital Transformation Program and through HB 19-1320 (Hospital Community Benefit Accountability) to work closely with providers in their community to ensure access to low-income Coloradans
- Utilizing associations and existing relationships to raise awareness of impacts, ensure adoption of modification to address gaps
- Elimination of CICP would also eliminate the CICP Advisory Council so the Department should identify a method to continue to engage stakeholders and/or advisors related to the Department's charity care policies

Rationale for These Two Major Changes:

- If FQHCs offer a sliding fee scale above 200% FPG, they must prove that no federal 330 grant funds are used. Most FQHCs used CICP to offer Sliding Fee Scale discounts to patients with incomes between 201 - 250% FPG. Although PCF allocations are determined based on the number of uninsured patients below 200% FPG, FQHCs may use PCF to offer sliding fee scale discounts above 200% FPG.
- Eliminating CICP reporting requirements and duplicative audits will decrease administrative burden on both hospitals and clinics.
- Hospital Discounted Care ensures low-income Coloradans still have access to discounted care and establishes minimum requirements for hospital charity care programs including uniform patient rights, screening tool, and streamlined application process.

Hospital's Point of View Regarding Ending CICP Requirements Colorado has 52 CICP hospitals including critical access and general acute care	
Pro	Con
• No need to complete annual provider CICP application • Ability to use a single application for all discounted care	• Number of payments capped at 36 v. currently unlimited duration w/CICP (Clarification: CICP copays are much

• Single appeal process • Keep the same sliding fee scale for DSH • Align auditing requirements across discounted care • Removing the stigma of the word “indigent” may result in more patients applying for assistance • Less confusion for both staff and patients • Would not need to follow both Hospital Discounted Rules and CICP Rules	lower than payment plans allowed under Hospital Discounted Care) • No carry over from hospital to hospital under Hospital Discounted Care; patient will be rescreened each time they visit a new hospital unless the hospital makes a policy to accept other hospital determinations • If there were unintended changes to the copay table under the program transition, hospitals would need to update their electronic health record systems

Clinic’s Point of View Regarding Ending CICP Requirements

There are 18 CICP participating primary clinic providers in the state, 16 of which are FQHCs, and these providers have nearly 200 clinic locations serving Coloradans in urban, rural, and frontier locations.

Pro	Con
• Ability to use a single application for all discounted care • Reduced administrative burden by eliminating the need to complete an annual CICP application and submit to audits. • Increased flexibility to determine programs to benefit uninsured patients.	• CICP rules explicitly state the funding can be used for sliding fee scales between 201 – 250% FPG. Clinics will need HCPF's written statement that PCF may be used to offer discounts to patients above 200% FPG, to meet FQHC requirements • PCF funding is a proportion of tobacco tax dollars, and because of beneficial public health efforts, tobacco use is decreasing in Colorado, therefore PCF funding will continue to decline year over year. • There would no longer be a specific requirement for clinics to use funding to offer services to those earning between 201-250% of FPG • Department will no longer be publishing a CICP manual and an application for clinic use

Patient’s Point of View Regarding Ending CICP Requirements

In FY 2020-21, approximately 40,000 people utilized CICP in clinics and hospitals.

Pro	Con
• Preserves access to hospital and clinic services • Simplifies patient understanding of what discounts they qualify for • Eliminates need for patients to apply for CICP in clinic settings; clinics will only	• Potential increase in out of pocket (10% cap under current CICP v. Hospital Discounted Care allowing 4% +2% +2% per episode)

have to follow their organization’s fee scale process ● Will result in a single dataset that can be used to help assess and improve services over time ● Hospitals using existing CICP application as a starting point will help providers by keeping things consistent with how it has looked in the past	● Patients aware of CICP may be confused about their ability to access discounted care. ● The population of Coloradans making between 201-250% FPG may not qualify for clinic discounts (unless clinics have their own program with broader limits) ● Less coordination between the hospitals and clinics is a risk, especially in rural areas

Five Factors Remain in Effect:

Regardless of these recommendations, or the Department’s decisions, the following five factors remain in effect:

- Clinics can continue to use PCF for patient's sliding scale
- DSH audit requirements
- Ability for patients to access care regardless of insurance
- Requirement to screen for Health First Colorado and CHP+
- Lawful presence will no longer be a requirement for state programs as of July 1, 2022

Implementation Considerations:

- Smooth Transitions for Providers: Elimination of CICP will require changes to law that may take one or more years to implement. And elimination will create a change in the current program structure. The Department should invest in additional collaborative engagement of providers to define how best to effect smooth transitions, aligning with remaining federal requirements (e.g., Health Resources and Services Administration applications), promoting consistency across providers (e.g., how to meet the needs of the population earning between 201-250% of FPG, etc.), and provide guidance on the timeline of implementation (e.g., what happens to those seen BEFORE an implementation date but screened AFTER the implementation date).
- Notification of Patients: Patients familiar with CICP and those on current payment plans may learn of the program’s termination. A comprehensive communication strategy should be developed to clarify the impact and timing of program changes.
- Effects on CHASE hospital provider fee methodology and supplemental payments
- How hospitals and clinics can be incentivized to work together regarding eligibility for discounted care
- How the clinic sliding fee scale and Hospital Discounted Care can be aligned