Primary Care Fund

Fiscal Year 2024-25 Annual Report

COLORADO
Department of Health Care Policy & Financing

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Executive Summary

The information in this report, authorized in section 25.5-3-304, C.R.S., and which has historically been included in the Colorado Indigent Care Program (CICP) Annual Report, provides comprehensive information on Colorado's Primary Care Fund (PCF) Pursuant to HB 24-1399. Information will now be reported in this report, the Primary Care Fund's new annual report. This report also contains data reported pursuant to section 25.5-3-505, C.R.S., associated with screening, discounted care, payment plan, and collections practices for the Hospital Discounted Care program.

The Primary Care Fund provides critical financial support to Community Health Centers and safety-net clinics that deliver comprehensive outpatient primary care to low-income, uninsured Coloradans. In FY 2024-25, the Primary Care Fund distributed $49.89 million to 33 qualified providers, supporting care for 119,621 low-income, uninsured patients served during the calendar year 2023.

Even though tobacco-tax revenue continues to decline, the Primary Care Fund has remained stable thanks to federal matching dollars allowed under SB 21-212. In FY 2024-25, the state received almost $25 million in federal funds, which supplemented about $18.46 million from tobacco taxes and a one-time $6.5 million General Fund boost to help with the effects of the Medicaid continuous enrollment unwind.

Recent laws—HB 24-1399 and SB 24-116—will significantly reshape Colorado's safety-net programs. HB 24-1399 ends the CICP on July 1, 2025, clarifies that Primary Care Fund eligibility includes patients at or below 200% of the federal poverty level, and requires the Department to publish an annual Primary Care Fund report starting in 2026.

The Primary Care Fund continues to play a key role in Colorado's health care. By offsetting uncompensated care costs and supporting clinics that serve medically underserved communities, the program enables providers to maintain access to essential primary care services for residents who would otherwise go without.

Payments to Safety Net Program Providers

The General Assembly appropriates funding for safety net programs to offset some of the uncompensated care costs for lower-income, uninsured Coloradans through the budget process. Payments to Community Health Centers and other safety net clinics are made through Primary Care Fund payments, financed with tobacco-tax revenue and federal matching funds.

In 2024-25, more than $49 million in tobacco-tax revenue, General Fund, and federal matching funds were paid to Primary Care Fund grant recipients.

Passage of House Bill 24-1399

HB 24-1399 made changes to the Colorado Indigent Care Program (CICP), Hospital Discounted Care, and the Primary Care Fund, including:

- Sunsetting the CICP effective July 1, 2025,

- Updating the language for the Primary Care Fund to include patients at or below 200% of the federal poverty guidelines (rather than only those "below 200%") effective July 1, 2025 and;
- Creating a requirement for an annual report for the Primary Care Fund beginning February 1, 2026.

Introduction

The purpose of this annual report is to inform stakeholders and policy makers about the status of the Primary Care Fund, and to report data associated with the Hospital Discounted Care program. HCPF prepared this report pursuant to section 25.5-3-304(1), C.R.S., as enacted through HB 24-1399. At a minimum, the report must include:

(a) The number of uninsured or medically indigent patients served who have an annual household income at or below two hundred percent of the federal poverty guideline;

(b) The allocation of money to qualified providers;

(c) The state department's recommendations concerning the primary care fund; and

(d) The information presented by the state department to the general assembly pursuant to section 25.5-3-505(6), C.R.S.

Primary Care Fund Overview

The Primary Care Fund was created through HB 05-1262 in accordance with Section 21 of Article X (Tobacco Taxes for Health-Related Purposes) of the State Constitution, following voter adoption of Amendment 35 in the 2004 general election. Its governing statute is section 25.5-3-301, et seq, C.R.S. (2024). The Primary Care Fund provides funding to Community Health Centers and safety net clinics that make basic health care services available in an outpatient setting to low-income, uninsured Coloradans.

In FY 2024-25, the Department paid $49,888,989 to 33 qualified providers, based on 119,621 uninsured or medically indigent patients served in calendar year 2023 who have an annual household income at or below two hundred percent of the federal poverty guidelines. The State department has no new recommendations for the General Assembly concerning the Primary Care Fund.

Qualification for funding and awards is made through an annual application process. A provider's allocation is determined by the number of medically indigent patients they served, compared to the total number of medically indigent patients served by all qualified providers in the previous calendar year.

Patients do not apply for the Primary Care Fund; rather, Community Health Centers and safety net clinics provide no-cost or low-cost health care services to qualifying patients on a sliding scale fee basis. These sliding scale fee schedules must guarantee that the patient's payment is below usual and customary charges.

Providers

Provider Eligibility Requirements
The Primary Care Fund requires that providers meet specific criteria, defined in statute. In FY 2024-25, there were 33 qualified Primary Care Fund clinics. Pursuant to section 25.5-3-301, C.R.S. (2024): A "Qualified provider" means an entity that provides comprehensive primary care services and that:

- Accepts all patients regardless of their ability to pay and uses a sliding-fee schedule for payments or that provides comprehensive primary care services free of charge;
- Serves a designated medically-underserved area or population, as provided in section 330(b) of the federal "Public Health Service Act", 42 U.S.C. 254b, or demonstrates to the state department that the entity serves a population or area that lacks adequate health-care services for low-income, uninsured persons;
- Has a demonstrated track record of providing cost-effective care;
- Provides or arranges for the provision of comprehensive primary care services to persons of all ages; and
- Completes initial screening for eligibility for the state medical assistance program, the children's basic health plan, and any other relevant government health-care program and referral to the appropriate agency for eligibility determination.
- Is a community health center, as defined in Section 330 of the federal "Public Health Services Act", 42 U.S.C. Section 254b; or at least 50% of the patients served by the provider are Eligible Patients or patients who are enrolled in the Medical Assistance Program, the Children's Basic Health Plan, or any combination thereof.

Program Administration

Reporting Requirements
HCPF requires Primary Care Fund providers to annually submit information sufficient to establish the provider's eligibility status. This information includes

- An annual application that includes the total number of patients served, the total number of low-income, uninsured patients who have an annual income below 200% of the federal poverty guideline, and the number of patients enrolled in Medicaid, CHP+ and CICP.
- Documentation demonstrating the quality assurance program in place at the provider's facility.
- Verification from an outside entity of the number of patients served.

Provider Compliance Audits

HCPF audits Primary Care Fund provider applications for accuracy and validity. Approximately one-third of all Primary Care Fund providers are audited each year. The results from the data validation process have improved the transparency and efficiency of the Primary Care Fund program. Through the audit, HCPF verifies the number of unique low-income, uninsured patients reported on the application and verifies correct copayments were charged.

HCPF requires providers to submit a compliance audit statement with a corrective action plan when the audit finds a 7% or higher error rate within the co-pay section of the audit. During FY 2024-25, HCPF audited 10 providers.

Common findings include:

- Patients included in the low income, uninsured count that should not have been;
- Not verifying that patients yearly income is below 200% of the FPG;
- Not charging the appropriate sliding fee scale co-pays

Reimbursement for Providers Clinics

In FY 2024-25, $49,888,988 was allocated to 33 Primary Care Fund qualified providers. This included a one-time General Fund appropriation of $6.5 million for which federal matching funds were drawn to assist Community Health Centers during the COVID-19 PHE unwind. With their application for FY 2024-25, Primary Care Fund clinics reported serving 119,621 unique low-income, uninsured patients in calendar year 2023.[1]

While the amount of tobacco tax revenue collected has decreased in recent years, tobacco-tax dollars in the Primary Care Fund accounts for approximately $18 million annually. SB 21-212, Primary Care Payments Align Federal Funding, directed HCPF to seek federal matching funds for the Primary Care Fund monies. This is part of the effort to eliminate the Clinic Based Indigent Care line item. The Centers for Medicare and Medicaid Services approved a federal match for Primary Care Fund dollars. State Plan Amendment (SPA) CO 23-0032 was approved on January 17, 2024 allowing us to draw down federal matching funds.

[1] Allocations to providers in FY 2024-25 are based on the number of people served in CY 2023 who met income and eligibility requirements. The Department does not receive data on CY 2024 participants until applications from providers are received for FY 2025-26.

Table 1. FY 2024-25 Primary Care Fund Payments

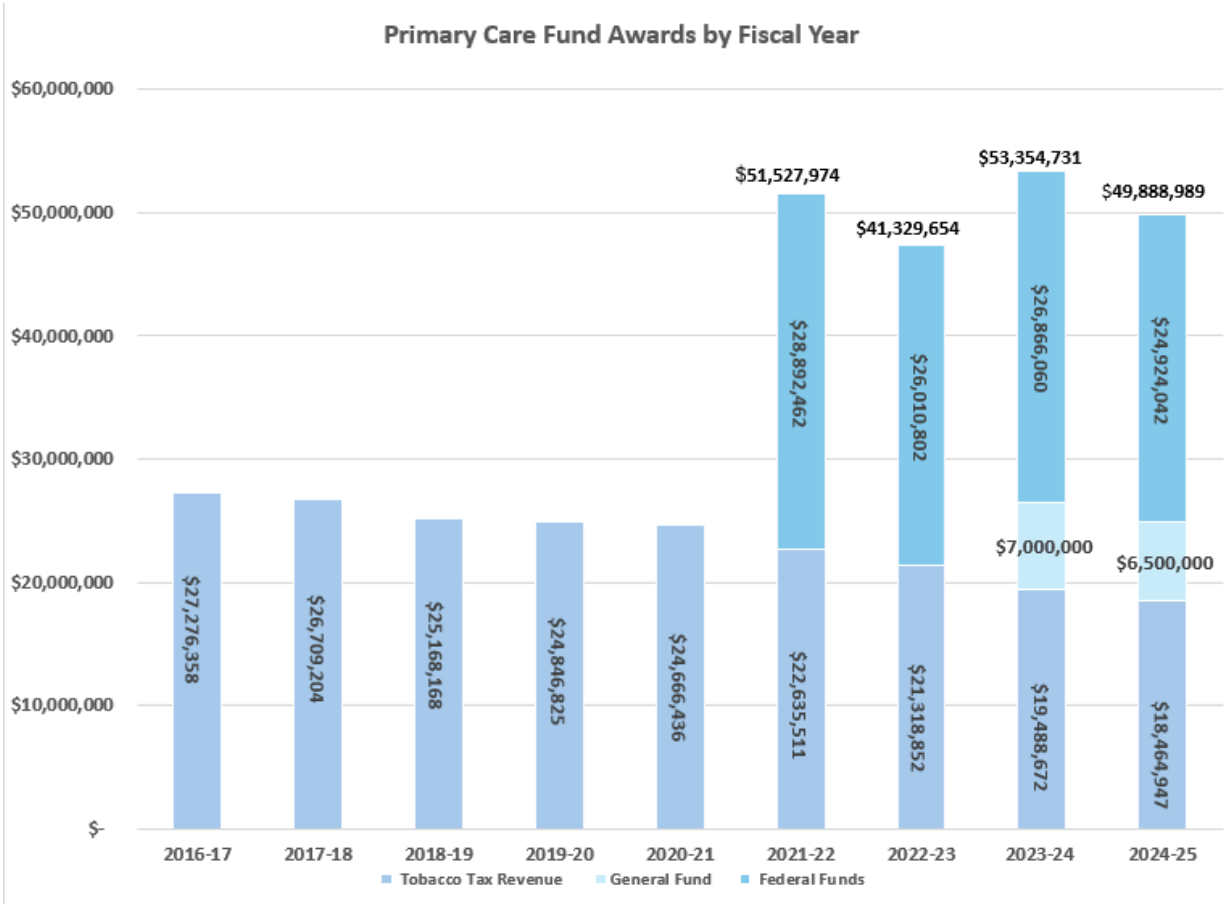
Primary Care Fund Fiscal Year 2024-25 Final Awards					
Primary Care Fund Provider	**Patients Served (CY 2023)**	**Total Tobacco Tax Revenue**	**Total General Fund**	**Total Federal Funds**	**Final 2024-25 Awards**
Basin Clinic	51	$7,872.47	$2,771.25	$10,643.72	$21,287.44
Carin' Clinic	59	$9,107.36	$3,205.96	$12,313.32	$24,626.64
Clinica Campesina Family Health Services	14,416	$2,225,283.82	$783,340.72	$3,008,624.54	$6,017,249.08
Clinica Colorado	1,798	$277,543.03	$97,700.24	$375,243.27	$750,486.54
Colorado Coalition for the Homeless	5,758	$888,816.89	$312,879.85	$1,201,696.74	$2,403,393.48
Denver Health and Hospital Authority	26,655	$4,114,521.38	$1,448,386.99	$5,562,908.37	$11,125,816.74
Denver Indian Health and Family	206	$31,798.59	$11,193.69	$42,992.28	$85,984.56
Doctors Care	291	$44,919.37	$15,812.44	$60,731.81	$121,463.62
Family Medicine Clinic for Health Equity	1,225	$189,093.55	$66,564.40	$255,657.95	$511,315.90
High Plains Community Health Center	763	$117,778.27	$41,460.11	$159,238.38	$318,476.76
Hopelight Medical Clinic	1,457	$224,905.56	$79,170.88	$304,076.44	$608,152.88
Inner City Health Center	1,714	$264,576.61	$93,135.82	$357,712.43	$715,424.86
Kids First Health Care	518	$79,959.56	$28,147.23	$108,106.79	$216,213.58
La Clinica Tepeyac, Inc.	3,059	$472,193.62	$166,220.81	$638,414.43	$1,276,828.86
Marillac Clinic, Inc.	1,517	$234,167.28	$82,431.18	$316,598.46	$633,196.92
Metro Community Provider Network	10,741	$1,658,003.16	$583,647.52	$2,241,650.68	$4,483,301.36

Table 1. FY 2024-25 Primary Care Fund Payments

Mountain Family Health Centers	2,771	$427,737.34	$150,571.39	$578,308.73	$1,156,617.46
Northwest Colorado Visiting Nurse Association	730	$112,684.32	$39,666.95	$152,351.27	$304,702.54
Olathe Community Clinic, Inc.	1,855	$286,341.67	$100,797.52	$387,139.19	$774,278.38
Open Bible Baptist Church	196	$30,254.97	$10,650.30	$0.00	$40,905.27
Peak Vista Community Health Center	10,295	$1,589,157.67	$559,412.64	$2,148,570.31	$4,297,140.62
Plan de Salud del Valle, Inc.	11,730	$1,810,667.26	$637,388.08	$2,448,055.34	$4,896,110.68
Poudre Valley Health System, Inc	285	$43,993.19	$15,486.41	$59,479.60	$118,959.20
Pueblo Community Health Center	2,895	$446,878.24	$157,309.34	$604,187.58	$1,208,375.16
Rocky Mountain Youth Medical and Nursing Consultants, Inc.	1,933	$298,381.91	$105,035.91	$403,417.82	$806,835.64
SET of Colorado Springs	118	$18,214.73	$6,411.92	$24,626.65	$49,253.30
Southwest Colorado Mental Health Center	795	$122,717.86	$43,198.94	$165,916.80	$331,833.60
Summit Community Care Clinic, Inc.	1,904	$293,905.41	$103,460.09	$397,365.50	$794,731.00
Sunrise Community Health	8,038	$1,240,762.44	$436,771.14	$1,677,533.58	$3,355,067.16
Uncompahgre Combined Clinic	68	$10,496.62	$3,695.00	$14,191.62	$28,383.24
University of Colorado College of Nursing	1,256	$193,878.78	$68,248.88	$262,127.66	$524,255.32
Uptown	2,493	$384,824.68	$135,465.34	$520,290.02	$1,040,580.04

Table 1. FY 2024-25 Primary Care Fund Payments					
Valley-Wide Health Systems, Inc.	2,031	$313,509.40	$110,361.06	$423,870.46	$847,740.92
Total	119,621	$18,464,947.01	$6,500,000.00	$24,924,041.74	$49,888,988.75

Figure 1. Primary Care Fund Awards by Fiscal Year



Hospital Discounted Care Data

Under Hospital Discounted Care, all Colorado general and Critical Access hospitals, and all licensed health care professionals who provide services within those hospitals, report data to HCPF to evaluate compliance with the legislative requirements. These requirements include: screening and eligibility determination, payment plans, and collection practices across race, ethnicity, age, and primary language spoken in the home. Prior to this year's submission, hospital data submissions included information from the professionals for patients seen at their facilities. Senate Bill (SB) 24-116 changed the reporting requirement to direct professionals to report their own data to HCPF effective September 1, 2025.

Section 25.5-3-505, C.R.S. requires hospitals and professionals to report data annually to HCPF by September 1 for the prior state fiscal year. This report includes data covering FY 2024-25 for the hospitals and January through June 2025 for the professionals. Subsequent data submissions from professionals will cover the state's full fiscal year. Pursuant to sections 25.5-3-505(6) and 25.5-3-304(1)(d), this report contains the aggregated data collected for the program and the Department's analysis.

Overall, 84 of the 85 hospitals met the statutory reporting requirements.[2] In total, 67,863 patients received financial assistance for their hospital bills through Hospital Discounted Care and/or the Colorado Indigent Care Program (CICP) during FY 2024-25. This represents an increase of 3,690 patients, or 5.75%, from the 64,173 reported in 2023-24.

Sixteen professional groups submitted data for 8,692 Hospital Discounted Care-eligible patients they served at hospital facilities. HCPF is working in collaboration with the hospitals to identify additional professional groups and improve their comprehension of reporting requirements in hopes of increasing reporting compliance for this group in the future.

Hospitals are required to submit data including demographic information for all uninsured patients. Additionally, hospitals report data for all insured patients who requested financial assistance. Hospitals are also required to provide patients' screening and application status including whether the patient:

- was still in the process of completing their screening or application,
- was determined eligible for Hospital Discounted Care and/or CICP,
- was determined eligible for the hospital's internal program if they did not qualify for Hospital Discounted Care or CICP,
- decided to remain self-pay,
- applied and qualified for Health First Colorado/Child Health Plan Plus (CHP+), or

[2] Kit Carson County Memorial Hospital reported FY 2024-25 data, but was unable to provide patient screening information. Their patients are included in the total patient demographics but HCPF could not determine which patients were eligible for Hospital Discounted Care from their submission.

- was not contacted and/or was unreachable, and therefore had no available screening information.

Professionals are required to submit data including demographic information for all Hospital Discounted Care patients they served within hospital facilities. Hospitals are solely responsible for the screening and application processes, and therefore are also responsible for informing professionals of their shared patients who are determined eligible for Hospital Discounted Care. Professionals expressed challenges related to reporting patient demographics due to communication issues with hospitals as well as limitations of their own systems to store demographic information. To help mitigate these issues, HCPF was able to allow professionals to report patient hospital Medical Record Numbers alongside the professional's patient Medical Record Number, which enables HCPF to pull the patients' demographics from the hospital submissions. This process was successful for most professionals' data, but some patient data were unable to be linked and are included in the "not provided" demographics set in the professional data submissions.

A. Patients Determined Eligible

In FY 2024-25, the 84 reporting hospitals provided discounted care for 67,863 patients through Hospital Discounted Care and/or CICP. This represents an increase of 3,690 patients, or 5.75%, from the 64,173 patients who received such care in 2023-24.

HCPF identified some reporting discrepancies in the FY 2023-24 data. As a result, HCPF held training for providers in May 2025. The training provided reporting and data submission best practices. HCPF found FY 2024-25 reported data showed improved data reporting from the previous year. The FY 2024-25 data will continue to inform updates to the reporting template and future training for providers. HCPF will continue helping resolve any remaining issues, such as patients being included in the demographics but not having any screening information submitted, or insured patients who did not request financial assistance being included.

The following charts and tables illustrate demographics of only the patients determined eligible for Hospital Discounted Care and/or CICP during FY 2024-25. The data submitted by professionals contains a subset of the Hospital Discounted Care eligible patients submitted by the hospitals, and therefore the professionals' reported patients are not added to the total number of patients served under Hospital Discounted Care. For information on all patients included in the hospital reported data for FY 2024-25, see All Patients Included in Hospital Data and Identified Inconsistencies within this Appendix B.

Figure 1. Hospital Discounted Care Patients by Race (reported in Hospital data)

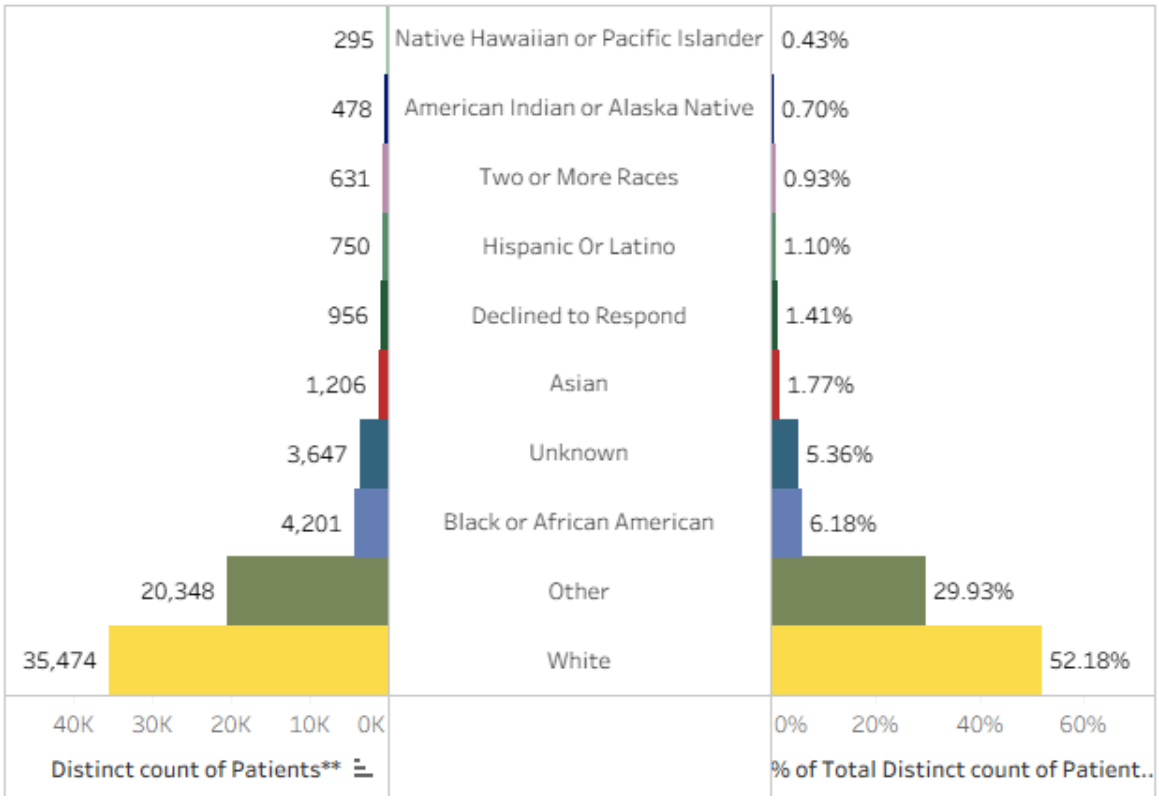


Figure 2. Hospital Discounted Care Patients by Race (reported in Professional data)

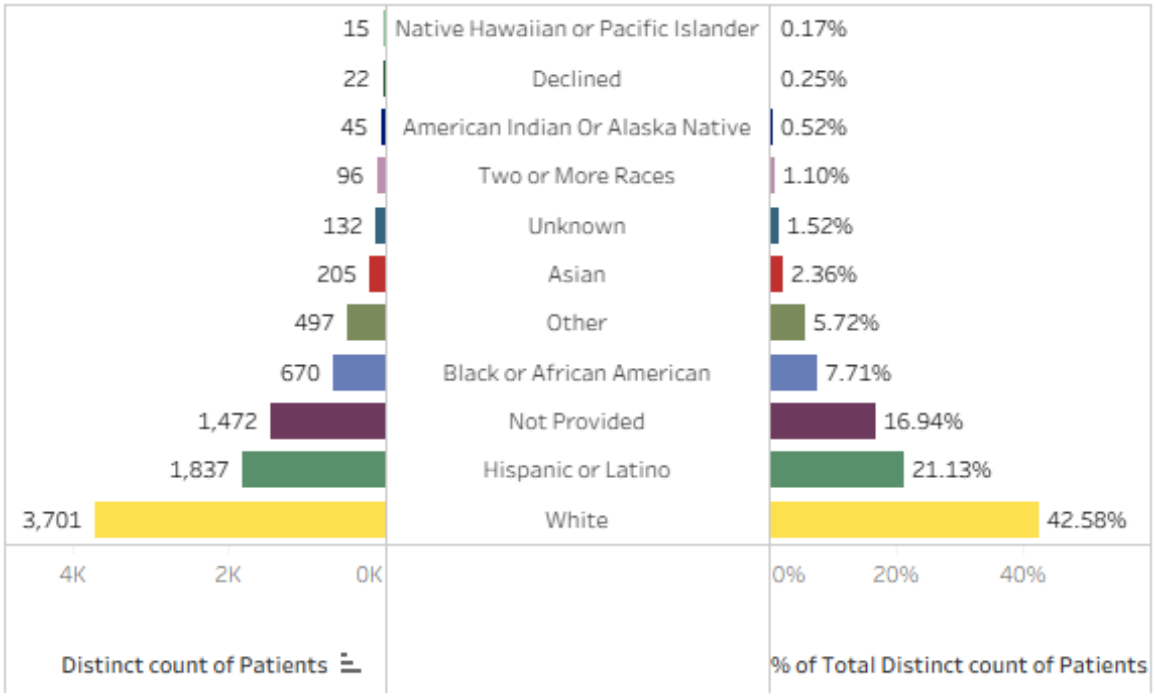


Figure 3. Hospital Discounted Care Patients by Ethnicity (reported in Hospital data)

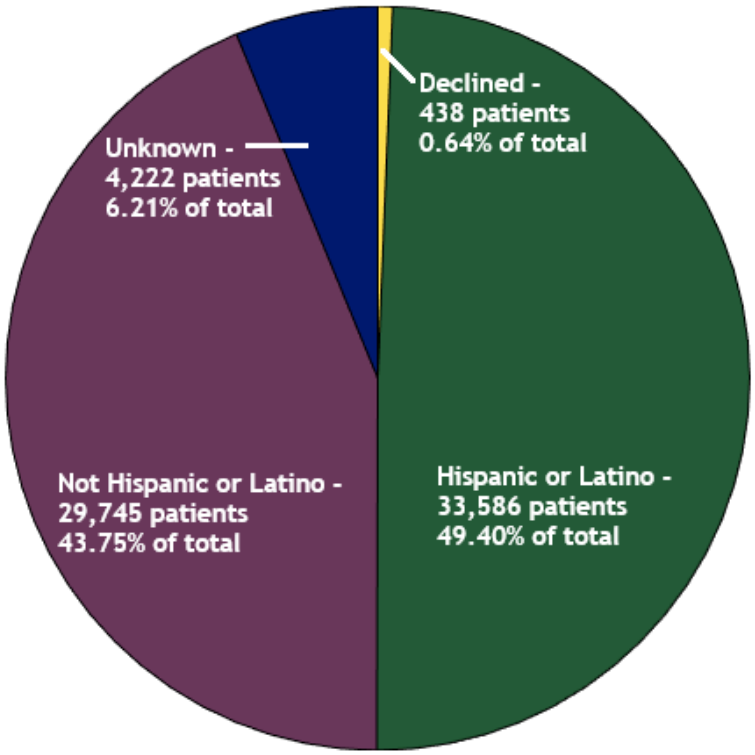


Figure 4. Hospital Discounted Care Patients by Ethnicity (reported in Professional data)

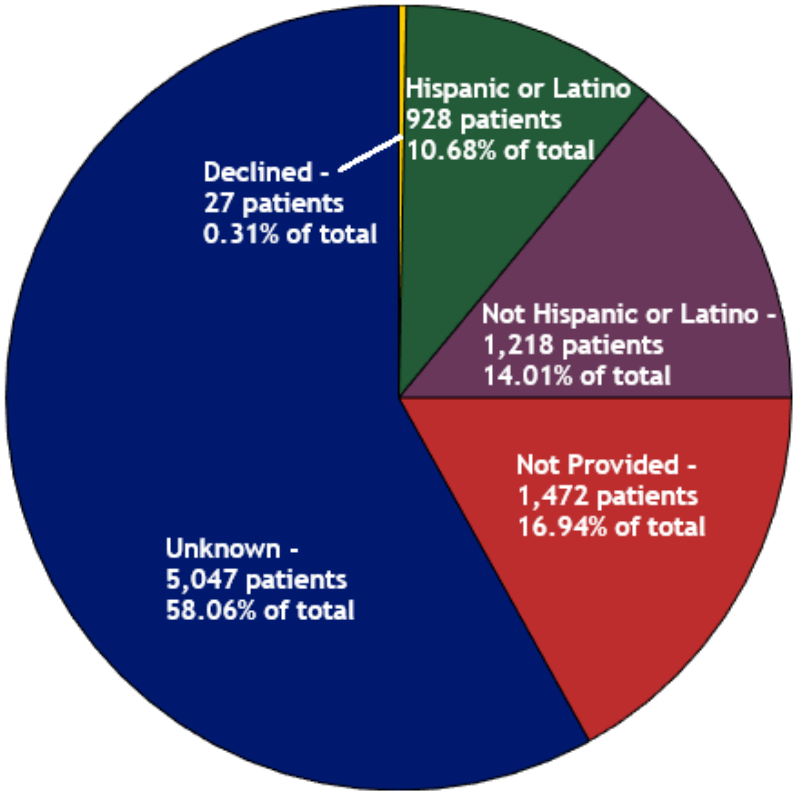


Figure 5 and Table 7 show patients' reported preferred language, the vast majority being English and Spanish. The Other category includes all languages reported as the preferred language for less than 50 patients, and the All Other category includes all languages reported as the preferred language for at least 50 patients within the Hospital reported data, including the Declined group which includes 60 patients. The All Other grouping is broken out in Figure 6.

Figure 5. Hospital Discounted Care Patients by English, Spanish, Unknown, Other, and All Other Languages (reported in Hospital data)

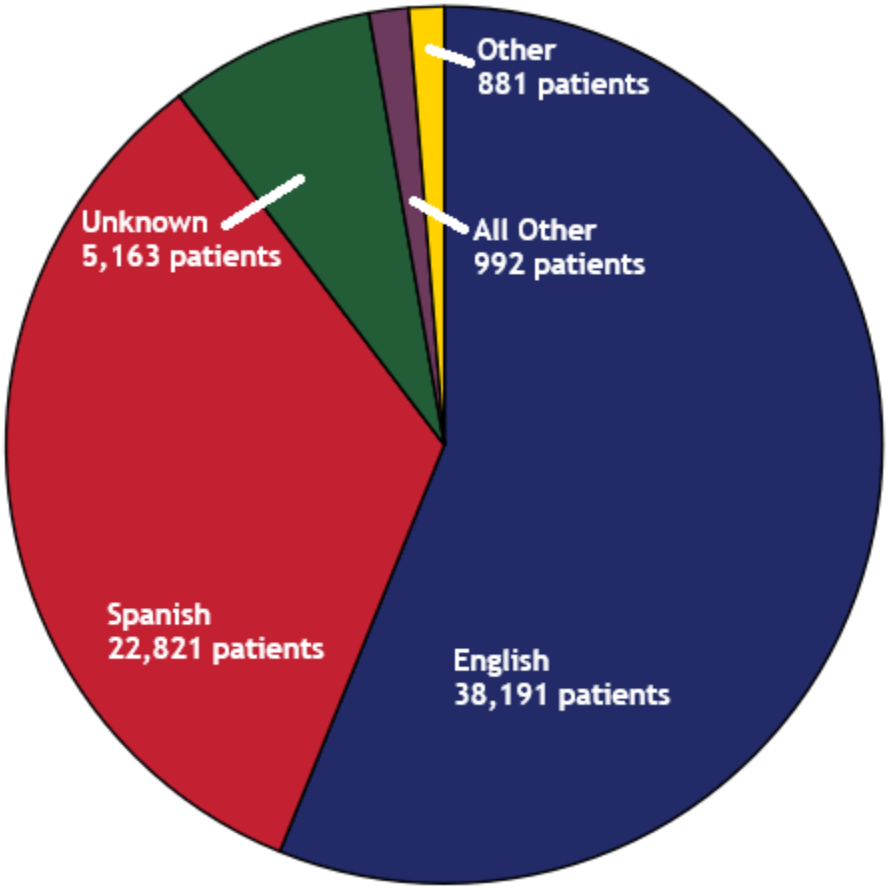


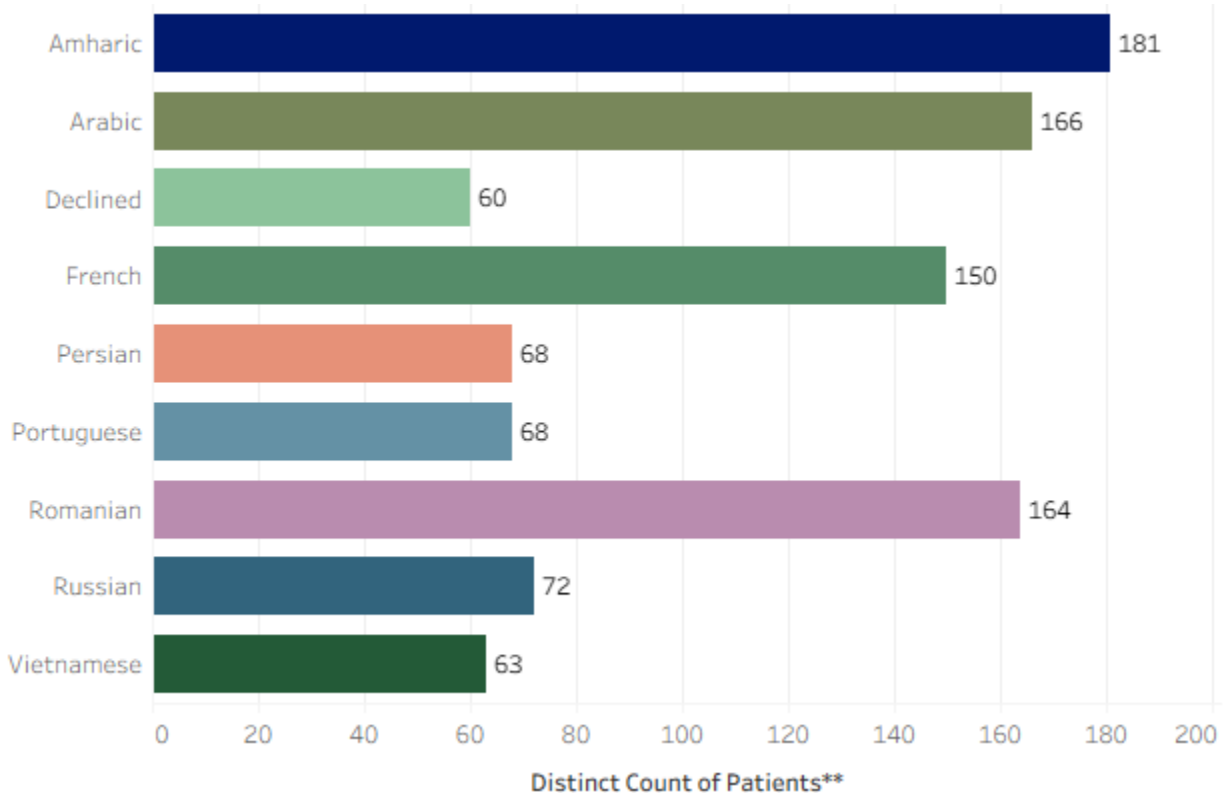
Table 7. Hospital Discounted Care Patients speaking English, Spanish, Unknown, or Other Languages not included in Figure 6 (reported in Hospital data)

Preferred Language	Distinct Count of *MRNs	Percent of Total *MRNs
English	38,191	56.18%
Other	881	0.05%
Spanish	22,821	33.57%
Unknown	5,163	7.59%
Total	**67,056**	**98.64%**

**MRN= Medical Record Number*

Figure 6 only includes languages other than English, Spanish, unknown, and other, which are included as All Other in Figure 5. These four groupings far exceed the number of patients reporting preferred languages included in the All Other category, making analysis challenging to view within the same graph. Preferred Language indicates a patient's primary language for communication; it does not imply that this is their only spoken language.

Figure 6. Hospital Discounted Care Patients by Preferred Language other than English, Spanish, Unknown, or Other (reported in Hospital data)



There were a small number of patients who were reported as having identified different preferred languages, during different encounters. Those patients have been included in the numbers for each language they identified as a preferred language.

Figure 7 and Table 8 show patients' reported preferred language, the vast majority being English, Spanish, and Not Provided. For consistency, the same language groupings were used for both the Professional data figures and the Hospital data figures

Figure 7. Hospital Discounted Care Patients by English, Spanish, Unknown, Other, and All Other Languages (reported in Professional data)

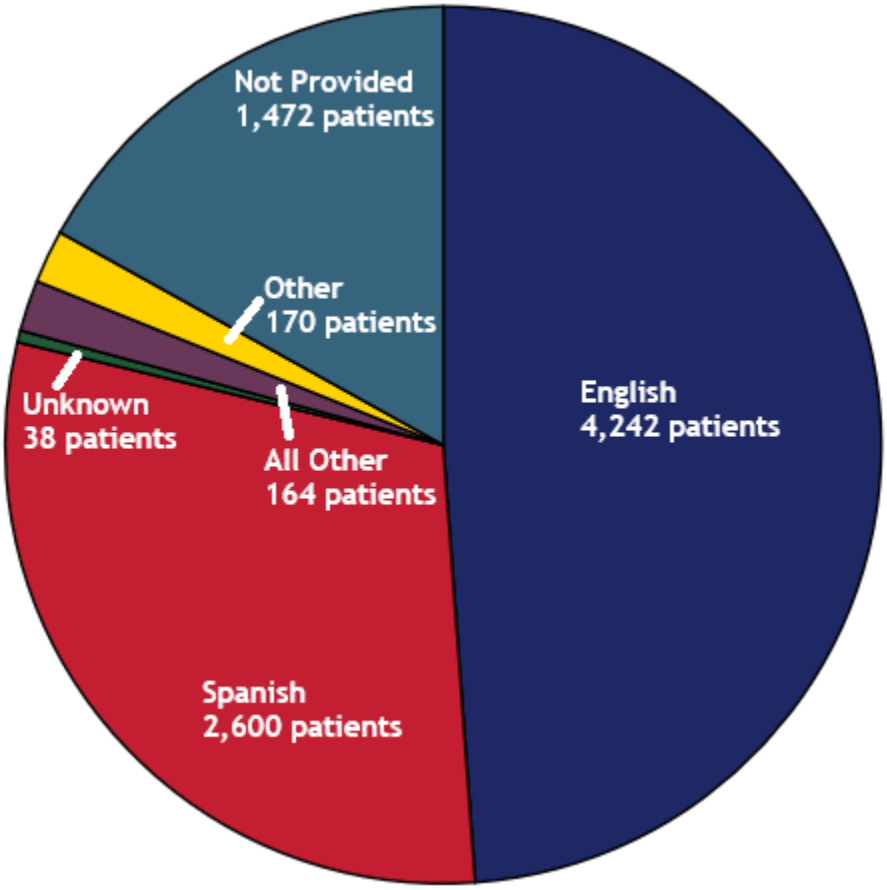
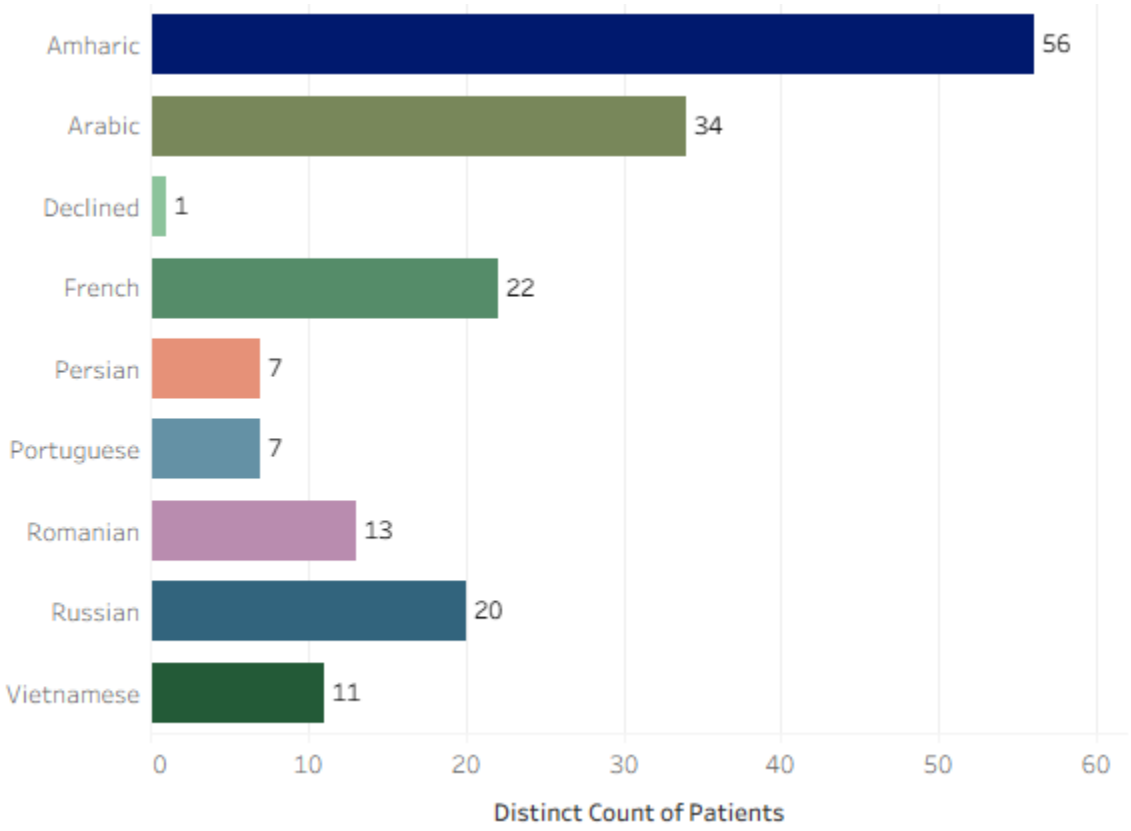


Table 8. Hospital Discounted Care Patients speaking English, Spanish, Unknown, or Other Languages not included in Figure 8 (reported in Professional data)

Preferred Language	Distinct Count of MRNs	Percent of Total MRNs
English	4,242	48.8%
Not Provided	1,472	16.94%
Other	170	1.96%
Spanish	2,600	29.91%
Unknown	38	0.44%
Total	**8,522**	**98.05%**

Figure 8 only includes languages other than English, Spanish, unknown, other, and Not Provided, which are included as All Other in Figure 7. These five groupings far exceed the number of patients reporting preferred languages included in the All Other category, making analysis challenging to view within the same graph. Preferred Language indicates a patient's primary language for communication; it does not imply that this is their only spoken language.

Figure 8. Hospital Discounted Care Patients by Preferred Language other than English, Spanish, Unknown, or Other (reported in Professional data)



There were a small number of patients who were reported as having identified different preferred languages during different encounters. Those patients have been included in the numbers for each language they identified as a preferred language.

Figure 9. Hospital Discounted Care Patients by Age (reported in Hospital data)

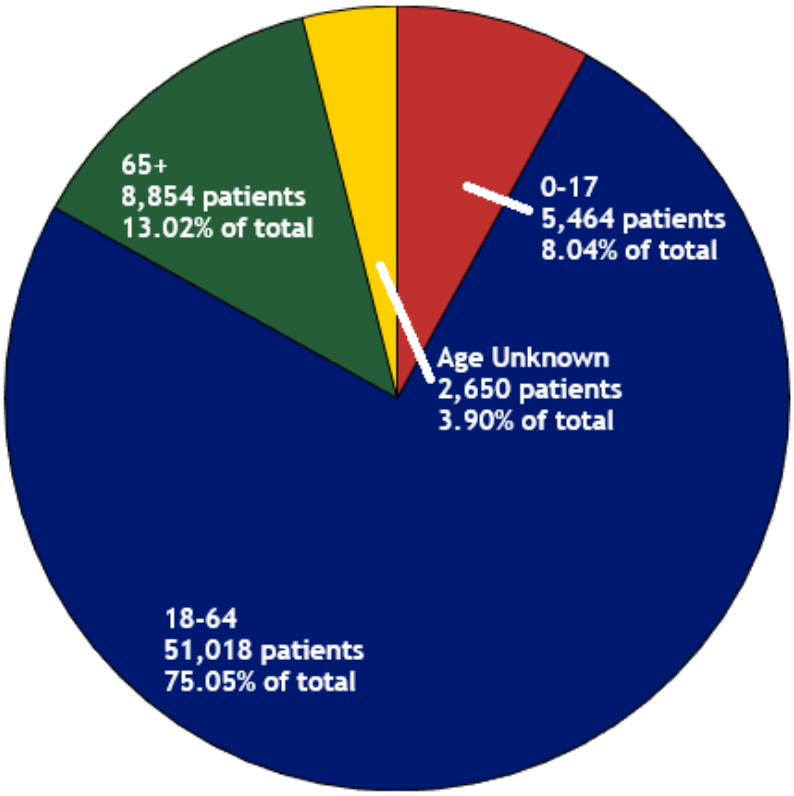
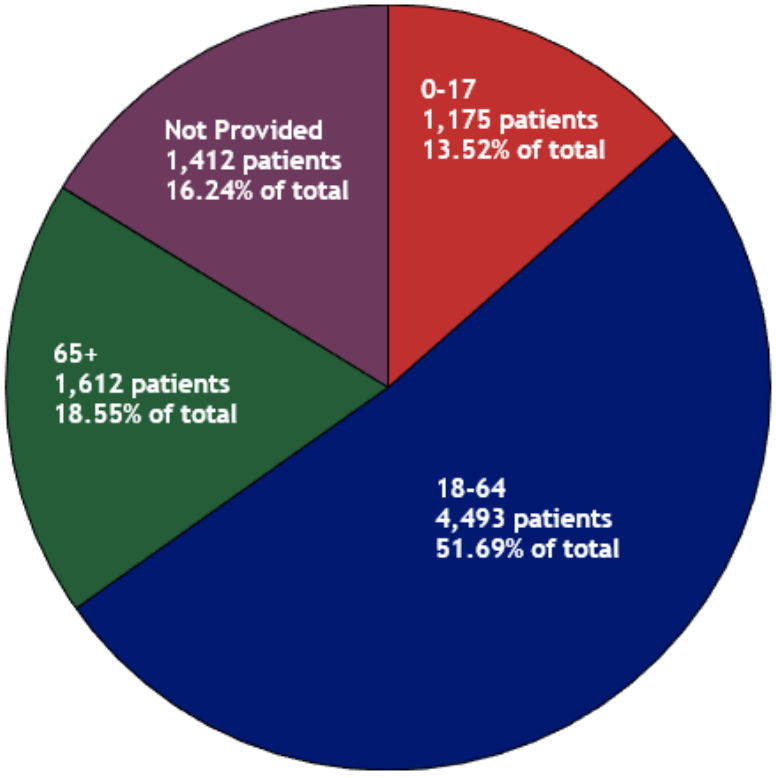


Figure 10. Hospital Discounted Care Patients by Age (reported in Professional data)



B. All Patients Included in Hospital Data and Identified Inconsistencies

HCPF staff identified issues within portions of the FY 2024-25 data submissions. One identified issue is the erroneous inclusion of certain insured patients in the data from hospitals. Hospitals are required to include all uninsured patients and any insured patients who requested financial assistance in their data. However, the cumulative data showed many patients were included who were insured but did not have any screening information included, implying they may not have requested financial assistance or did not complete the financial assistance process. HCPF will continue to hold annual training sessions on data reporting requirements under Hospital Discounted Care, and corrective action plans may be required for continuing data issues. Additionally, HCPF will continue to provide necessary updates and guidance compliance in future submissions.

The cumulative data from 85 reporting hospitals included 303,580 distinct patients, a decrease of 62,166 patients, or -17.0%, from the 365,746 distinct patients reported in FY 2023-24. HCPF believes, but does not have solid data at this time to confirm, that the reduction between FY 2023-24 and FY 2024-25 is due to a combination of updates to the reporting template based on issues identified in the FY 2023-24 data submission and a better understanding by the hospitals as to which patients actually need to be included in the data.

Of the total 303,580 patients included in the data, hospitals reported demographic data only for 114,274 patients; no screening information was included. This represents a decrease of 103,744 patients, or -47.59%, from the 218,018 patients who were reported with demographic information but were missing screening information in FY 2023-24. HCPF believes, but does not have solid data at this time to confirm, that this reduction is due to a better understanding by the hospitals of which patients actually needed to be included in the data and an increase of patients that had screening information reported even if the patient was only ever in "Best Efforts" status.

Table 9. All Patients Reported by Final Determination

Final Determination Group	Number of patients
All Distinct Patients Included in Hospital Data	303,580
Hospital Discounted Care	67,863
Individual Hospital Charity Care Program	16,884
Medicaid	6,301
Self-Pay	50,149
No Final Determination	52,421
Screening Data not submitted	114,274

Figure 11. All Patients with a Reported Final Determination

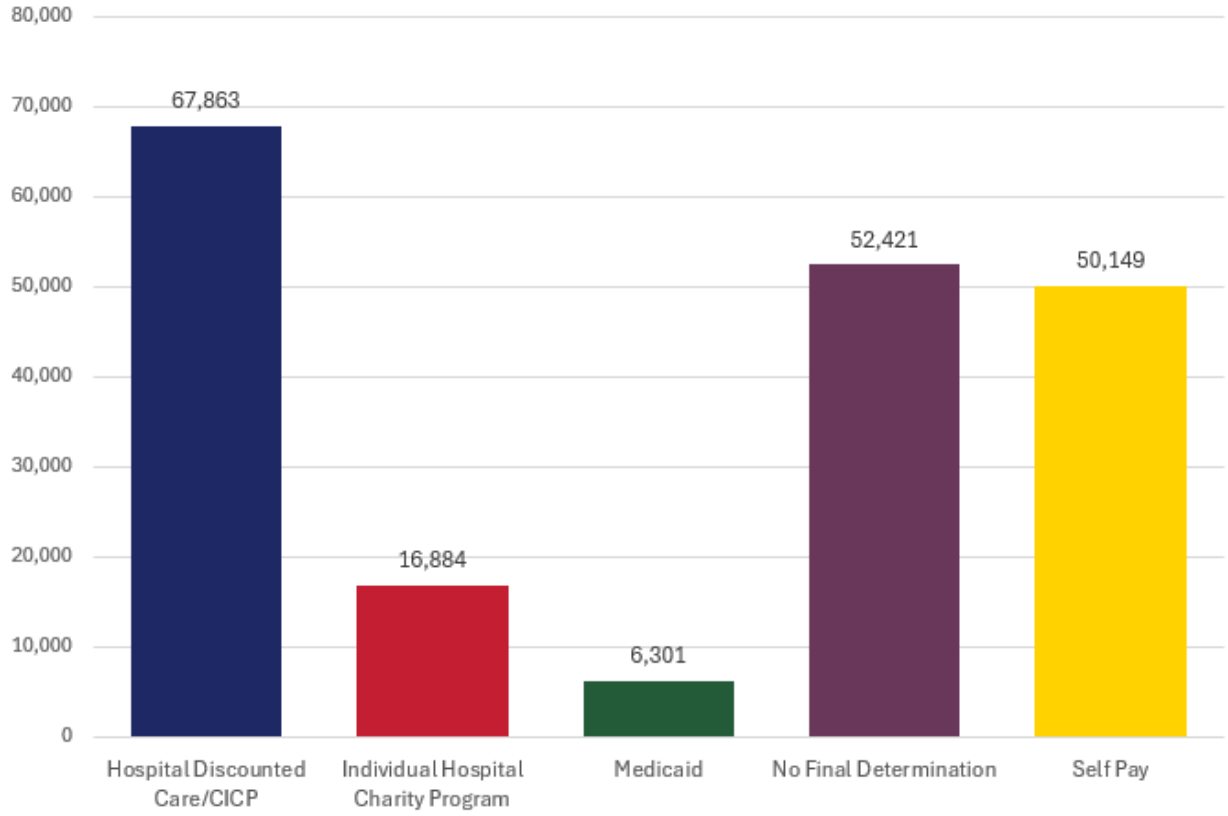


Figure 11 does not include the 114,274 patients whose final determinations were not included in the submitted data. Additionally, some patients may be included in multiple determination groups in Table 9 and Figure 11 if they had a change in status during the fiscal year, so the numbers will not sum to the total number of distinct patients included in the data. For example, a patient may have chosen to remain self-pay at one point in the year and then decided to apply for Hospital Discounted Care and/or CICP at a later date of service.

The version of Figure 11 published in the FY 2023-24 annual report included "Other" and "No Screening Data Reported" final determination categories. Recent reporting template updates require reporters to choose one of the five options included in the graph in an attempt to improve data accuracy. HCPF analyzed the FY 2023-24 data, which was not limited to certain responses in the Final Determination field, and identified the five options included in the FY 2024-25 template as the only final determination categories that patients should be able to fall into.

The breakdown of the 114,274 patients without screening information is as follows:

- For 1,168 patients reported as uninsured and 319 patients reported as insured, only payment plan information was included - these patients are believed to have accessed services in FY 2022-23 and/or FY 2023-24 and have continuing payment plans into FY 2024-25.

    - Payment plans can last a maximum of 36 months of payments and are required to be reported in each fiscal year they are still ongoing, meaning the patient's demographics must also be reported each year of the payment plan.
    - Patient eligibility determinations are generally valid for a year but are not required to be updated if the patient does not seek new services once their original determination expires. As such, these patients may not have needed to be screened in FY 2024-25.
- For 16,495 patients reported as uninsured and 117 patients reported as insured, only collections information was included - these patients are believed to have accessed services in FY 2022-23 and/or FY 2023-24 and have been sent to collections in FY 2024-25.
    - There were 121 patients reported as uninsured and 9 patients reported as insured who were included in both the payment plan and collections information.
    - Collections can be started as early as 182 days after the patient's date of service, or at any point during an established payment plan if the patient misses three consecutive payments. The patient's demographics must be reported in any fiscal year they were sent to collections.
    - Patient eligibility determinations are generally valid for a year but are not required to be updated if the patient does not seek new services once their original determination expires. As such, these patients may not have needed to be screened in FY 2024-25.
- For 38,043 patients reported as insured, there was missing screening or application information - these patients likely should not have been included in the hospitals' reporting. This number represents a decrease of 14,674 patients, or -27.84%, from the number of insured patients reported without screening information in FY 2023-24.
- For 57,721 patients reported as uninsured and 541 patients reported with unknown insurance status, there was missing screening or application information - these patients are believed to have been correctly included, but it is unclear why screening information was not included for them. It is possible that some of these patients declined screening or did not respond to screening attempts. This number represents a decrease of 86,930 patients, or -60.1%, from the number of uninsured patients reported without screening information in FY 2023-24.

HCPF will hold annual training sessions which will include clarification on how patients like those identified above should be reported in order to ensure correct and complete data. Additionally, HCPF continues to hold monthly office hours for hospitals to ask questions, including questions about data reporting requirements.

The following figures and tables illustrate the demographics of all patients who were included in the Hospital data submitted for Hospital Discounted Care and CICP for FY 2024-25. This includes individuals whose reported final determinations did not indicate they were found eligible for Hospital Discounted Care or CICP.

Figure 12. All Patients Reported by Race

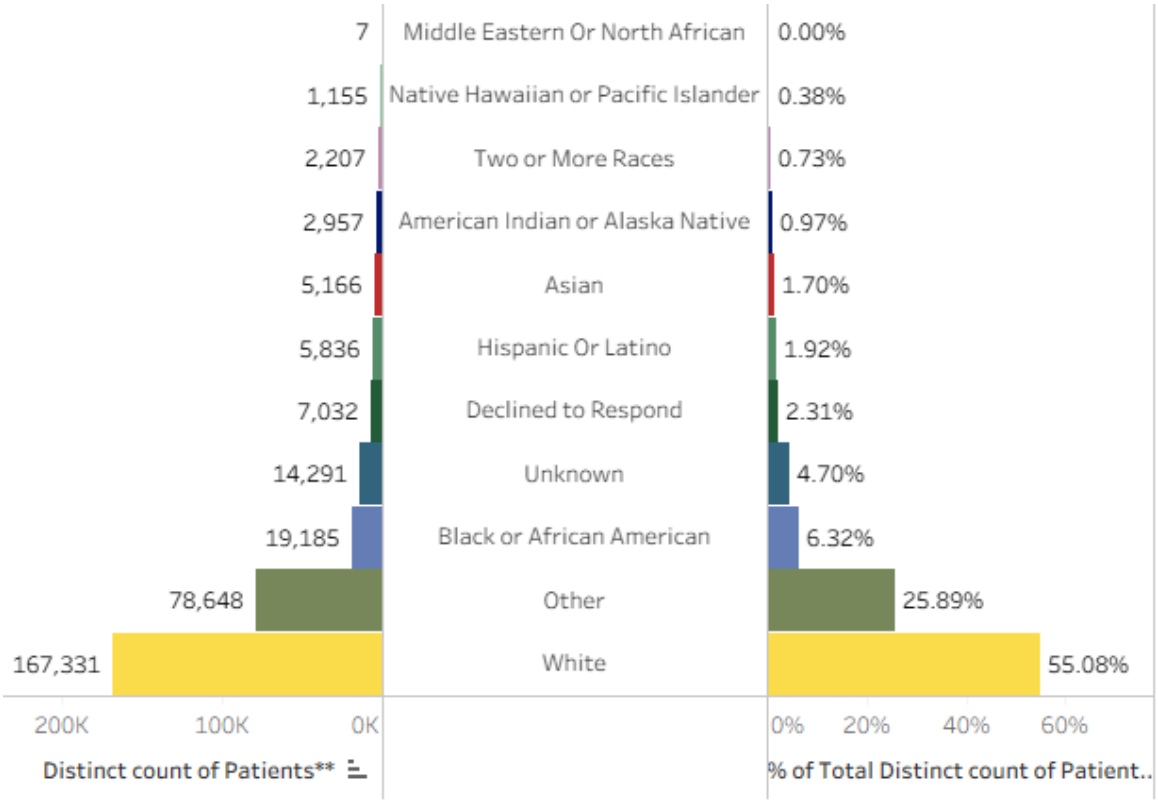


Figure 13. All Patients Reported by Ethnicity

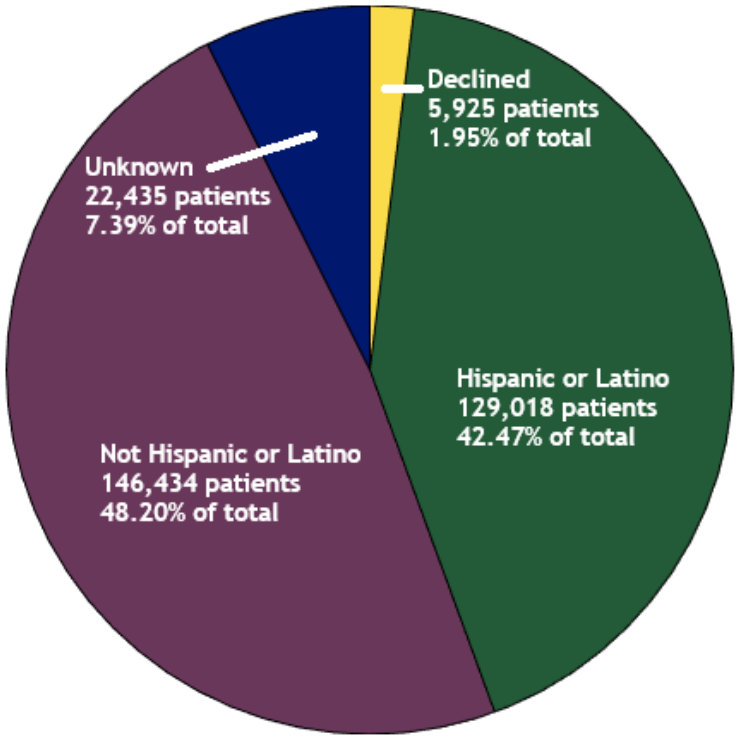


Figure 14 and Table 10 show patients' reported preferred language, the vast majority being English and Spanish. The same groupings of languages were kept as for the Hospital Discounted Care patients, for consistency.

Figure 14. All Patients by English, Spanish, Unknown, Other, and All Other Languages

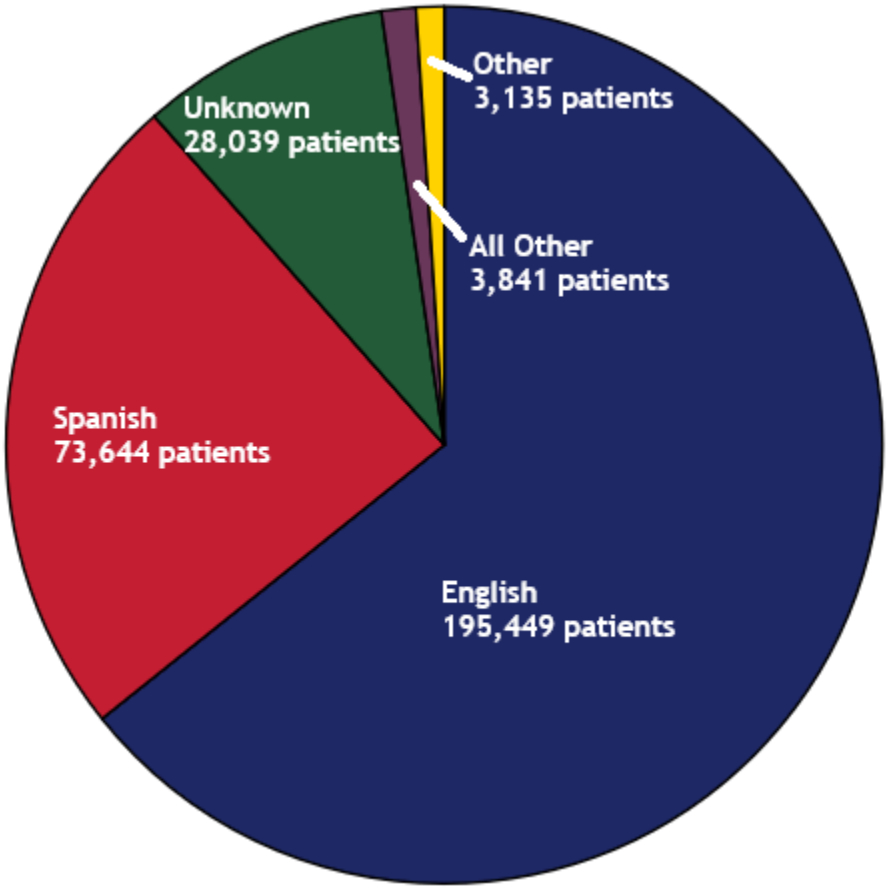


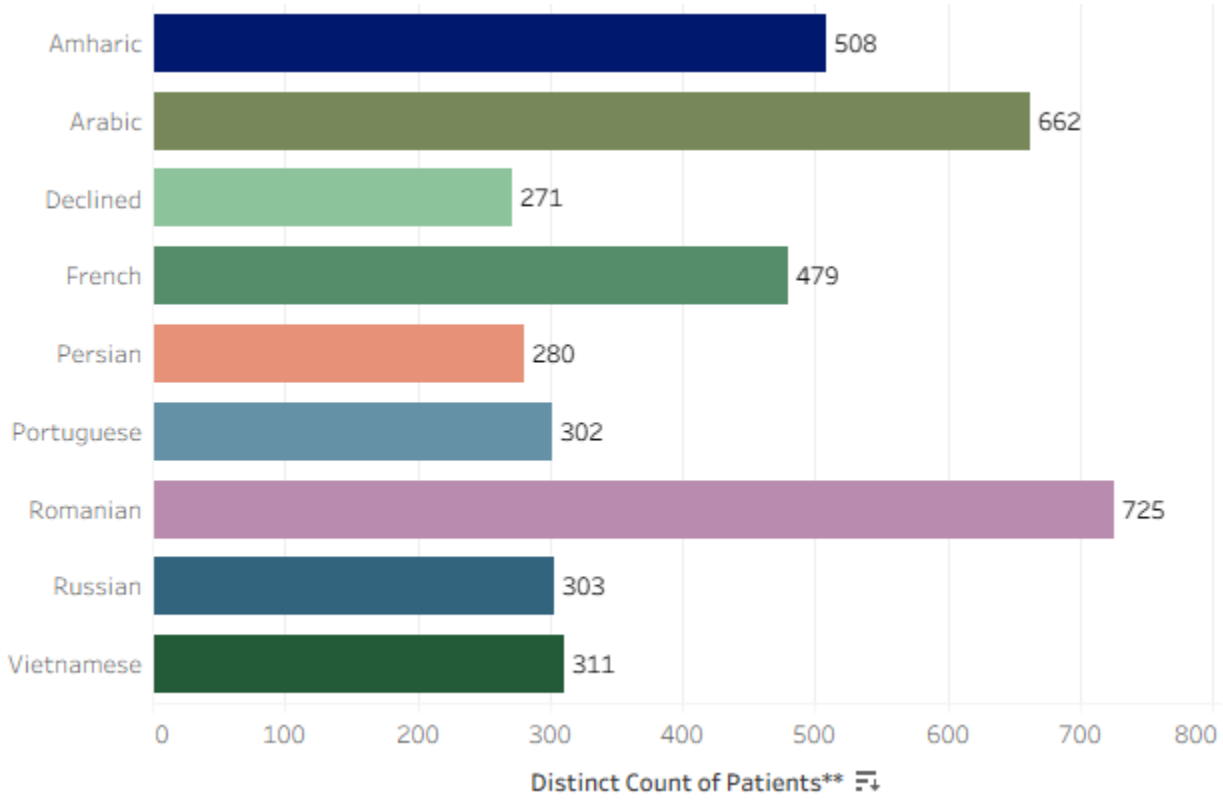
Table 10. Patients speaking English, Spanish, Unknown, or Other Languages not included in Figure 15

Preferred Language	Distinct Count of MRNs*	Percent of Total MRNs*
English	195,449	64.34%
Other	3,135	1.03%
Spanish	73,644	24.24%
Unknown	28,039	9.23%
Total	**300,267**	**98.84%**

**MRN= Medical Record Number*

Figure 15 shows patients' preferred languages other than English, Spanish, unknown, and other, because they were the vast majority of preferred languages reported. Preferred language indicates a patient's primary language for communication; it does not imply that this is their only spoken language.

Figure 15. All Patients Reported by Preferred Language, Excluding English, Spanish, Unknown, and Other



There were a small number of patients who were reported as having identified different preferred languages during different encounters. Those patients have been included in the numbers for each language they identified as a preferred language.

Figure 16. All Patients Reported by Age