Question and Answer Session

Hospital Discounted Care

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Residency

If a patient lives out of state but they work full time in Colorado, are they still eligible for Hospital Discounted Care?

- Hospital Discounted Care is only for Colorado residents, but providers can choose to extend Hospital Discounted Care to out of state patients either by policy or exception. Allowing patients who work in Colorado but reside in neighboring states to apply would be an example of a policy.

If a patient lived in Colorado for 10 years and they moved out 2 months after DOS, are they no longer eligible?

- Since the Date of Service (DOS) happened while the patient was a Colorado resident, they would be eligible to apply for that DOS only.

If a patient is visiting their family in Colorado for 6 months, but then will return to their country after, can the patient declare residency?

- Applicants who do not prove Colorado residency, can declare their intent to stay in the State to meet the residency requirements. In this case, the patient is stating their intent to only stay in Colorado for a set time period, so they do not meet the residency requirements.

If a patient was life flighted to Colorado, are they eligible?

- Patients that are out of state residents who may be life flighted to Colorado are not eligible for Hospital Discounted Care.
  - Facilities may extend Hospital Discounted Care to these patients by exception or policy.

Screening and Best Efforts

If an insured patient calls after the 181 days, can they still be screened?

- At minimum, insured patients can request to be screened within 181 days of their date of service (DOS) or date of discharge (DOD), whichever is later OR within 45 days of the date of their first bill after their insurance adjustment if the bill is not adjusted until after the 181-day window.

If the patient called for a screening after the 181-day timeline, what is the proper way to handle it? Is the patient no longer eligible until they have another DOS?

- Providers must allow patients to complete a screening and begin an application within 181 days of their date of service or date of discharge. Providers are encouraged to extend those timelines, if possible, especially if the patient has good cause.

If a parent comes in to be seen with 3 minor children and they do not have insurance, does each child need the decline screening form or need to be screened?

- Every patient that is uninsured must be screened regardless of the age.
- The parent can sign one decline screening form for themself and the minor children or complete one screening that includes them.

How many attempts for screening are required before starting best efforts?

- Providers must attempt to contact the patient by at least one method of contact which should be the patient's preferred method of contact, if indicated (*These methods can include phone calls, SMS messages, emails, portal messages, and mailings*)
- After the first contact attempt, the inclusion of the Patient Rights within the patient's bill can be considered as a screening contact attempt – best practice would be to attempt to contact the patient twice via their preferred method of contact

For hospitals using a third-party company to send statements that include the Patient Rights, does the hospital have to do any additional contact for Screening Best Efforts?

- Hospitals must contact patients at least once, with best practice being twice, via their indicated preferred method of contact if any
- After the first, preferably second, attempt, the inclusion of the Patient Rights in the statements sent by the third-party company can be considered a contact attempt.

Decline Screening

If a patient decides to decline to be screened, can they apply at a later time?

- A Decline Screening form is not final. Patients may choose to apply at any time between the screening and their bill being sent to collections
  - Facilities are encouraged to allow patients to apply even if it is past the 181 days

Does an out of state patient need to sign a Decline Screening form even though they do not qualify?

- Out of state patients that are uninsured need to complete the screening or sign the decline screening form
  - On the screening form once you get to the residency question you may stop the screening if your facility does not extend Hospital Discounted Care to out of state patients

If a patient verbally states they want us to stop contacting them and they don't want to apply, is having the detail of the verbal opt out documented on a Decline Screening form all that is needed to stop future contact to patient?

- Households who request the provider cease contact about their account should have their request documented in their record, and Screening Best Efforts can be stopped.
- Verbal declines can be accepted **but** providers must note the Decline Screening form with:
  - date & time
  - who from the household was spoken to
  - reason for decline if possible
  - providers signature

Application

A patient claims they are single (not married) but has a fiancé, do we count their income?

- Per Colorado law, only the patient's spouse or civil union partner must be included in the application if they are legally married, so neither the fiancé nor their income need to be included

Is there an age limit someone can apply for Hospital Discounted Care?

- There is no age limit on who can apply.

Would a deceased person be counted in the current household size? If so, how would we issue the card for alive family members and deceased members?

- The deceased individual should be included in the current household size if the application is covering a DOS for the deceased person
- Then if the household wants to apply for services going forward, a new application would be need to be done removing the deceased person and their income

If adult siblings live together but have separate income, do they have to be on the same application?

- In this situation, adult siblings are considered roommates. Roommates can be part of the same household if and only if all roommates agree to being on the same application. Unmarried roommates can all be considered separate households.

Are elective services covered?

- As long as the elective service is medically necessary it is covered under Hospital Discounted Care
  - Medical necessity is determined by the patient's Physician

Medically Necessary Definition

- Hospital Discounted Care follows the same definition of Medically Necessary as Health First Colorado, as defined below.
- CCR 10-2505-10, Section 8.076.1.8. Medical necessity means a good or service:
  a. Will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all;
  b. Is provided in accordance with generally accepted professional standards for health care in the United States;
  c. Is clinically appropriate in terms of type, frequency, extent, site, and duration;
  d. Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider;
  e. Is delivered in the most appropriate setting(s) required by the client's condition;
  f. Is not experimental or investigational; and
  g. Is not more costly than other equally effective treatment options.

Is ambulance a covered service?

- Ambulance bills are not covered under Hospital Discounted Care

Income

Can we use an older paystub if the patient does not have a current one?

- Providers should use the most current information the patient provides, which may not cover the most recent pay period the patient was paid. As long as nothing has changed in terms of their hours or pay, an older pay stub works just as well as a more current one.

Where does child support and workers comp get entered on the application?

- Child support and workers comp are **not** counted as income, so they should not be entered on the Uniform Application.

Is FAMLI counted as an income source?

- HCPF is not counting FAMLI payments as an income source.

Is FAMLI different than FMLA?

- FAMLI and FMLA are two different things.
- Family and Medical Leave Insurance (FAMLI) is a Colorado program that pays for 12 weeks of family and medical leave, with a potential for an additional 4 weeks for cases with pregnancy or birth complications.
- Family and Medical Leave Act (FMLA) is a federal program that provides job protection for workers but does not make payments to workers.
  - Workers may receive sick, PTO, or short term disability payments from their employer while using FMLA

What would constitute an over payment from a HealthShare?

- As a reminder, Providers may not collect more than the allowed rate from the patient, so any payment the patient may have made would be above the allowed amount once the payment is applied would need to be refunded.

If a patient was receiving unemployment benefits within the past 30-days but have since exhausted all of their benefits and are no longer receiving it, does it still need to be counted?

- No, if the benefits are exhausted, it should not be counted in the application.

Do employment letters have to be notarized to verify that the information on the letter is accurate?

- Employment letters do not need to be notarized. Letters should be on the company's letterhead if they have one. Providers may call to verify the information in the letter if it is not on letterhead.

For applicants that are self employed and work from home, do we enter the full amount of the mortgage & utilities on the worksheet?

- On worksheet 2 you must answer the top 4 questions
  - Then enter the full amount of the mortgage and utilities. The application will automatically calculate a percentage of the amounts

UNIFORM APPLICATION
Worksheet 2 - Net Self-Employment Income

Does the self-employed household member operate their business from their home?	Yes
Square footage of household's home:	750
Square footage used for household member's home business:	100
Hours per week household member works out of their home:	40.00

What proof can you request for cash income?

- For patients that are paid in cash, they can show:
  - Bank receipts showing cash deposits
  - Ledgers (account book, list of income and expenses, etc.) or other documentation of payments from clients/customers
  - Letter from employer
  - Self declare either by writing a letter or verbally

Insurance, Health First Colorado, and CHP+

Why are patients with other insurance plans still eligible for Hospital Discounted Care and Medicaid members are not?

- Private insurance may not cover all services and patients may have high deductibles or copays they struggle to cover.
- Patients who are current Health First Colorado or CHP+ Members cannot be on Hospital Discounted Care or CICP because Health First and CHP+ cover all medically necessary services, which would be the same services that are discounted under Hospital Discounted Care and CICP.

If we submit a Medicaid application in the hospital, can we also submit a Uniform Application just in case Medicaid gets denied?

- A Uniform Application for the household could be completed while you are waiting for the Medicaid application determination. However, if the patient is approved for Health First Colorado, their eligibility for Hospital Discounted Care would need to be rescinded and any adjustments made would need to be undone.

How long do we hold the account for Medicaid to come through?

- Since each county may have different processing times, you should hold the account as long as needed, until you receive the Health First Colorado determination.

A patient that is 75 years old and has Medicare & private insurance, and the screening states they may qualify for MCD. Due to their age, they would not qualify. Do they need a denial letter?

- As a reminder, there is no denial letter required for Hospital Discounted Care, only for CICP.
- If the aging adult patient is not disabled and their income is under the Medicaid limit, on the application, you can put “Age” for the reason in the Code F - Other field

What are examples of third parties?

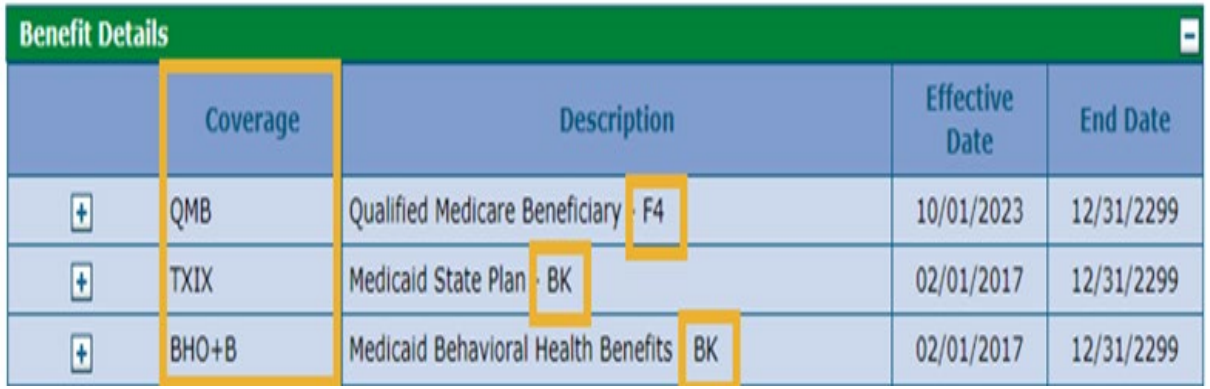
- Third parties means an individual, institution, corporation, or public or private agency which is or may be liable to pay all or any part of the medical cost of an injury, a disease, or the disability of an applicant for or recipient of Hospital Discounted Care
  - Private Insurance, Workers Comp, Medi-Share, Auto Insurance

Can patients with QMB apply for Hospital Discounted Care?

- Patients are allowed to apply if they have one of the following:
  - Qualified Medicare Beneficiary (QMB)
  - Specified Low-income Medicare Beneficiary (SLMB)
  - Qualifying Individual (QI-1)
  - Qualified Disabled and Working Individuals (QDWI)

What if a patient has QMB Dual?

- Patients that have QMB Dual are not eligible for Hospital Discounted Care/CICP
  - Example below shows a QMB Dual individual from HCPF's Benefit Plan & Program Aid Code Guide, both the QMB and the TXIX coverage sources are listed



Benefit Details

	Coverage	Description	Effective Date	End Date
+	QMB	Qualified Medicare Beneficiary - F4	10/01/2023	12/31/2299
+	TXIX	Medicaid State Plan - BK	02/01/2017	12/31/2299
+	BHO+B	Medicaid Behavioral Health Benefits - BK	02/01/2017	12/31/2299

Determinations

Can we accept determinations from other hospitals?

- We encourage facilities to accept determinations from other hospitals, as long as the determination is still valid at the time of service
  - Facilities are allowed, with the patient's permission, to request the patient's application and documentation from the first facility to complete an application at their own facility if there is a possibility the facilities count different deductions

What if the patient has a card that doesn't quite backdate far enough to cover their services at our facility?

- If it is easily determined that the application was completed at the other facility within 181 days of the date of service at your facility, there is no issue accepting a card that doesn't quite go back far enough to cover based on the card eligibility dates. Providers accepting cards that don't quite backdate far enough should notate the acceptance of the card for the earlier date in the patient's account so that it is available for auditing.
- For example, if the patient had services in March at your facility, their card has an effective date in April, and it is only July, the application was clearly done within 181 days of their March date of service.

If we accept a card from another provider, do we have to do a new application?

- Providers may accept cards or determinations from any other hospital provider, and may accept cards from federally qualified health centers (FQHCs), rural health clinics (RHCs), and other CICP Clinics using the process outlined in the operations manual.

Does a determination cover only the patient or the entire household?

- The determination covers the entire household that is included on the application unless a household member has specifically stated they want to be included in the household size only. By assigning each household member a "program" code on the application, it will place their names on the card and the determination will apply to them as well as the patient.

Data Reporting

Do we need to reach out to all non contracted physicians for collections data?

- Facilities are still responsible for reporting all their non employed physician Hospital Discounted Care approved patient billing information in their data sets

If our hospital writes off the total charges when a patient is approved under Hospital Discounted Care/CICP should we just leave the payment plan tab blank or report the amount that they should have paid in the payment plan?

- Facilities that write off approved accounts for Hospital Discounted Care/CICP, can leave the payment plans and collections tab blank.

For physician and radiology offices that complete procedures in the hospital, are they supposed to comply with Hospital Discounted Care?

- Any procedures provided within a hospital setting must comply with the Hospital Discounted Care law.

What is Third Party Liability column on the Visit-Admissions-Charges data template? Do we include the amount of an insurance adjustment?

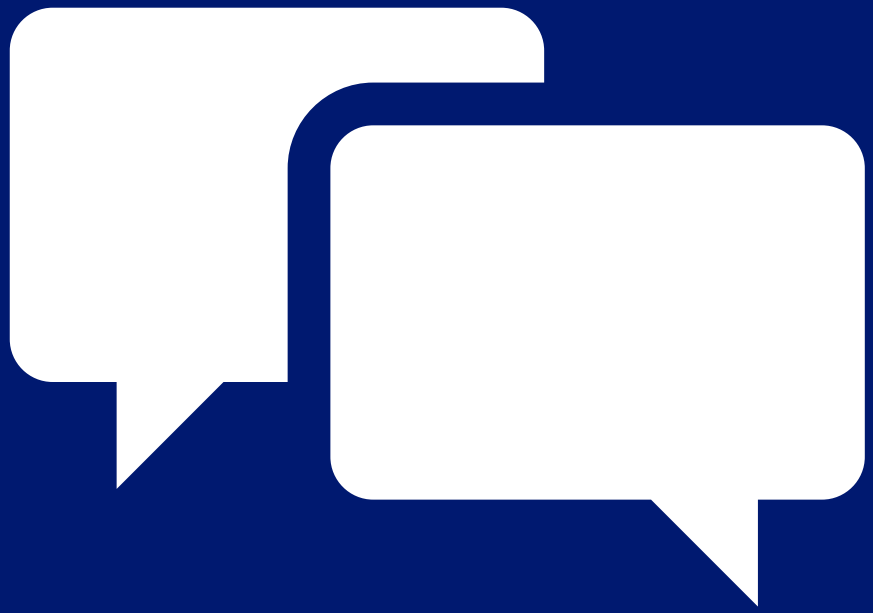
- This is the payment received or due by an insurance company or any third party associated with the account. Providers do not need to include the contractual adjustments in the Third Party Liability amount.

If you get a verbal decline screening, will that be marked in the signed decline screening column on the Screening-Application tab?

- Whether the patient verbally or physically signs the decline screening form you would enter that date into column G on the Screening-Application tab.

When is the data reporting due?

- Data covering July 2023 through June 2024 will be due **September 1, 2024**



Questions?

Contact Us

- Questions should be sent to: HCPF_HospDiscountCare@state.co.us
- Hospital Discounted Care Website: https://hcpf.colorado.gov/hospital-discounted-care
  - Operations manual, FAQs, flowcharts, and much more
- Office Hours
  - Every other Wednesday at 9:00 a.m.
  - Meeting link and call-in information available on the Hospital Discounted Care website, no need to register