Screening and Application

Hospital Discounted Care

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HDC Live

- Hospital Discounted Care went into effect on September 1, 2022
- Applies to any service provided on or after September 1, 2022
  - Services provided prior to September 1, can be discounted under HDC but not mandatory
  - For patients who are hospitalized before September 1, and discharged on or after that date, hospital would only be mandated to apply HDC to charges on or after September 1

Objectives

- CICP vs HDC
- Processes for Hospital Discounted Care (HDC)
  - Patient Rights
  - Screening
    - Uninsured vs Insured
  - Screening Best Efforts
  - Uniform Application
- Determination Notices
- Timelines
- Questions

CICP vs HDC

- CICP and HDC are closely aligned but there are some differences
  - CICP is a discount program with set copays that only some hospitals and clinics participate in, and participation is voluntary
  - Facilities may also have licensed health care professionals who also accept CICP and some who may not
  - CICP- SSN or sign No SSN Affidavit is required
  - If a patient appears eligible, a Health First/CHP+ denial is required if they want to be on CICP
- Hospital Discount Care is **not** a program, it is a Law
  - HDC - SSN is **not** required
  - Applying for Health First Colorado is **not** required

Step 1: Patient's Rights

Patient's Rights

- Facilities should have posted a copy of the Patient Rights in English & Spanish and Uniform Application including a link to the information on the Health Care Facility's main website
- Patient Rights (PR) Notice should be filled in with facility phone number that goes directly to the person/department that handles HDC screenings/applications
- Providers PR must be included in all their bills so if working with a billing company facilities need to ensure PR's are included in bill/statements

Patient's Rights (cont.)

- Process starts same for everyone, regardless of insurance status
- First step in the process: Provide patient and/or their guardian with Patient's Rights document in their preferred language
  - Written
  - Verbal for patients who need assistance
  - Before patient leaves facility

Step 2: Screening

Screening

- Screening is the first tab of the Uniform Application
- All self-attested information, no documentation needed
- Information on household size and income. *Inquiring about assets is not allowed*
- Coded to look at various households based on HDC/CICP and Health First Colorado household definitions
- If a patient is uninsured they must be screened even if the procedure is not medically necessary or if the patient does not want to be screened they have to sign the Decline Screening form

Screening Results

- Results of screening should be communicated to patient at the end of the screening
- Information on how to apply for various programs should be provided to patient to pursue further
  - PEAK/County offices for Health First/CHP+
  - Connect for Health Colorado for private health insurance options
  - Information on how to set up application appointment for HDC/CICP or other charity care

Insured vs Uninsured Patients

- Per the bill, all uninsured patients must be screened
  - Patients who sign the Decline Screening form are considered screened
  - "All uninsured patients" makes no exceptions for patients who live out of state or who are over income, these patients must either be screened or sign a Decline Screening form
- Insured patients may request to be screened either after their services or following their first bill after their insurance adjustment

Uninsured Patients

- Hospital should attempt to complete screening prior to patient leaving facility if possible
  - Patients who are not in the right state to complete paperwork should not be screened or sign a Decline Screening form
- If a screening cannot be completed prior to the patient leaving, hospital should do their best to schedule a screening appointment
  - Patient may decline to set up an appointment at the time
    - Follow up with patient to set an appointment or to collect a Decline Screening form
- Screenings and applications may also be completed during intake, scheduling, or other time prior to scheduling or scheduled services

Uninsured Patient Screening Timeline

- Screening may be done in person, over the phone, or via an electronic screening process
- Screening should occur on or within 45 days of date of service/date of discharge (DOS/DOD)
- At least one contact per the patients preferred method of contact (if indicated) should occur in the first 45 days after DOS/DOD
- If screening has not occurred within 45 days and patient has not signed a Decline Screening form, move into Screening Best Efforts

Question 1

- If an uninsured patient wants to schedule a non-medically necessary nasal reconstruction, does the hospital need to complete a screening for them?
  - A. Yes
  - B. No

Answer 1

- If an uninsured patient wants to schedule a non-medically necessary nasal reconstruction, does the hospital need to complete a screening for them?
  - A. Yes
  - B. No
- All uninsured patients must be screened or sign a Decline Screening form when receiving services at the hospital regardless of whether their service is medically necessary

Insured Patients

- Once Patient's Rights distributed, responsibility is complete for now
- Starts again if insured patient requests to be screened
  - Insured patients can request to be screened within 45 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
  - Providers can allow insured patients to complete a screening or application outside the two 45-day windows

Insured Patient Screening Timeline

- Hospital has three business days to respond to an insured patient's request to be screened
  - Screening does not need to happen in those three days, patient just needs to be contacted to schedule a screening
  - Screening must occur within 45 days of the insured patient requesting the screening
  - Screening may be done in person, over the phone, or via an electronic screening process

Residency vs Lawful Presence

- Colorado residents who are at or below 250% of the Federal Poverty Guideline qualify for HDC
  - Providers can choose to extend HDC to out-of-state residents either by policy or exception
- Lawful presence status does not factor in qualifying for HDC (or CICP)
  - No documents are needed nor should be requested related to lawful presence
  - This is due to Senate Bill 21-199 that removed the lawful presence requirement for all state programs

Question 2

- If a patient is staying with a family member who is a Colorado resident but the patient intends to stay only until they are well enough to travel home, is the patient eligible for HDC?
  - A. Yes
  - B. No

Answer 2

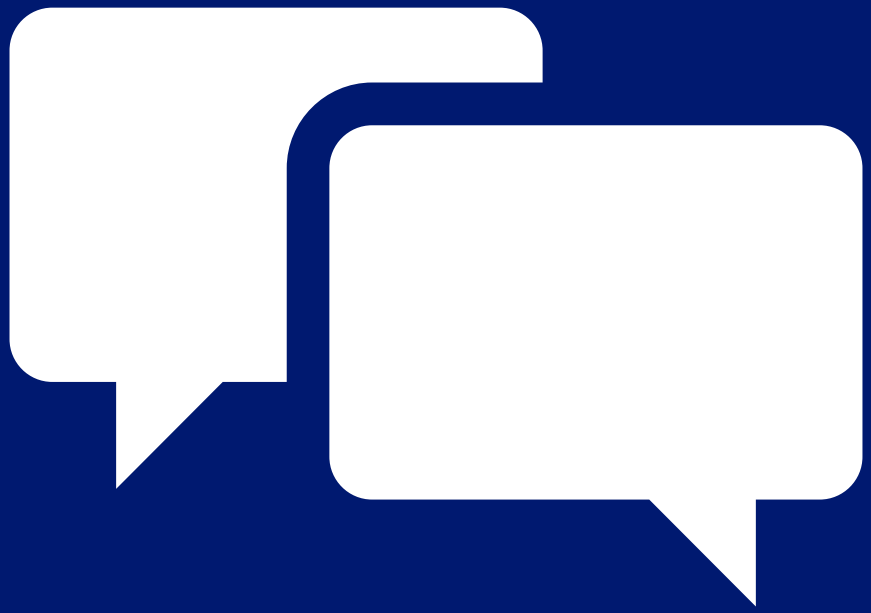
- If a patient is staying with a family member who is a Colorado resident but the patient intends to stay only until they are well enough to travel home, is the patient eligible for HDC?
  - A. Yes
  - B. No
- In general, non-residents are **not** eligible for HDC however facilities have the option to extend HDC to these patients either by exception or policy

Health First Colorado/CHP+

- Patients who are current Health First Colorado or CHP+ members are considered insured and are not eligible for Hospital Discounted Care (or CICP)

Health Sharing Ministries

- Patients who are part of a health sharing ministry (Medi-Share) are considered **uninsured**, must be screened
- Providers are allowed to continue creating one-time contracts directly with the Health Share for patients who are eligible for HDC



Questions?

Qualified Patient

- An individual who resides in Colorado whose household income is not more than 250% of the federal poverty guidelines
  - Hospitals can extend to non-Colorado residents
- Household means any person living at the patient's address and any other members who live outside of the state or country that the patient or their guardian provides 50% or more of their support
- Income includes employment, self-employment, and a short list of unearned income sources

Decline Screening Form

- Uninsured patients who do not want to be screened must sign a Decline Screening form
  - This form is not a final decision, a patient can request to be screened at a later date
- Decline Screening can be over the phone during Screening Best Efforts, scheduling, or intake

Decline Screening Form (cont.)

- A Decline Screening form only needs to be collected from uninsured patients who do not want to be screened
  - Patients who are screened and choose not to complete an application have completed the process (unless the decide they want to apply later)
- Signed Decline Screening forms must be kept in the patient's record for auditing purposes
- Health Care Facilities shall keep the signed Decline Screening Form on file until June 30th of the seventh state fiscal year after the patient's date of service or date of discharge, whichever is later

Signed Forms

- A Decline Screening form must be signed for each episode of care and any services provided related to the original episode of care
  - Patients may not sign a Decline Screening form for any unrelated services that have not yet happened
- One form may be signed for multiple past episodes of care
  - Patient may indicate a PAST date range their signed form covers – must not include any future dates

Date Range Line

First and Last Names of Patient: _____

Signature of Patient: _____

First and Last Name of Legal Guardian or Parent (if needed): _____

Signature of Legal Guardian or Parent (if needed): _____

Today's Date: _____ Date of Hospital Service: _____

Signature of Staff Member: _____ Date: _____

Household Decline

- Only one Decline Screening form is needed per household if multiple household members receive services the same day
  - Applies only to spouses and minor children
  - Two unmarried adult household members would each need to sign their own Decline Screening form
- Names of spouses and any minor children who receive service on the same date should be listed on the Decline Screening form

Question 3

- A family consisting of two adult parents, two adult children, three minor children, and a senior parent are involved in a hiking accident in which one parent, both adult children, and one minor child are all injured and receive treatment at the local hospital. How many Decline Screening forms must be collected if none of them want to be screened?
  - A. Two
  - B. Three
  - C. Four

Answer 3

- How many Decline Screening forms must be collected if none of them want to be screened?
  - A. Two
  - B. Three
  - C. Four
- Even though the adult children are part of the household, they must sign their own Decline Screening forms since they could be considered their own households due to their ages.

Step 2.5: Screening Best Efforts

Screening Best Efforts

- Patients may leave the hospital without being screened or signing a Decline Screening form
- In this situation, hospitals begin Screening Best Efforts
  - Contact household at least once a month
  - Use household's preferred method of contact
- After the first contact attempt, the inclusion of the Patients' Rights within the patient's bill can be considered as a screening contact attempt
- 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

Deceased Patients

- For a patient who passes away prior to being screened, the Health Care Facility shall present the Patient's Rights document to the patient's spouse, guardian, power of attorney, or executor of the patient's account
  - If there is no contact information for next of kin, the Health Care Facility may proceed with their current policy for handling accounts for deceased patients
  - A family member or other representative may complete the screening and determination process on behalf of the deceased patient or sign the Decline Screening form

Questions?

Step 3: Uniform Application

Uniform Application

- Applications are **not** to be filled out by patients
- Applications can be started at any point between the screening and 181 days past the patient's DOS/DOD, whichever is later
- Once an application is started, household has 45 days to submit all required documentation
  - If documentation is missing after 45 days, hospital may request new documentation to ensure most recent information is being used
  - If a 45-day application window ends on or after 182 days past the patient's DOS/DOD, the facility may begin the collection process on the 46th day
- Providers may accept documents in person, through the mail, via email, facsimile, etc.

45-Day Window Example 1

- A patient is screened two weeks after their DOS and decides to apply the same day. They submit their employment income but do not send their spouse's employment income prior to the 45-day mark past when their application was started. The hospital can request updated employment income for the patient so that the most recent information is being used for the application.

45-Day Window Example 2

- A household has been being contacted via Screening Best Efforts and finally decides to be screened and begin their application on day 154 past their DOD. However, the household does not send the self-employment documentation for one of the included household members until the 210th day past their DOD, which is outside of the 45-day window from when their application was started. The hospital can choose whether to allow the household to complete the application or begin the collections process.

Residency Documentation

- To show Colorado residency (in no particular order):
  - Colorado ID
  - Pay Stub with home address listed
  - Rental agreement or mortgage statement
  - Bank statement
  - Utility bill
  - Any official document that shows their name and address
- Patients can also self-declare their intent to remain in the state to satisfy the residency requirement

Employment Income Documentation

- For employed household members:
  - Paycheck stubs, payroll history, wage records, letter from employer, most recent tax return, or facility can call to verify payment information
- For self-employed household members:
  - Paycheck stubs, payroll history, wage records if they pay themselves as an employee of the business, business financial records (P&L, ledger, business bank statement showing deposits & withdrawals, invoices & receipts, etc.), most recent tax return

Employment Income Documentation (cont.)

- For household members who work for cash:
  - 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
- Patients who are experiencing homelessness are exempt from the documentation requirements and are allowed to use self-attested information for the screening and the application

Other Income Documentation

- For household members receiving unemployment benefits, their unemployment compensation documentation
- For household members receiving Short Term Disability, their Short Term Disability payment information
- For adult household members with no income, a letter attesting they have no income

Unearned Income

- Unearned income includes:
  - Social Security Income (SSI)
  - Social Security Disability Insurance (SSDI)
  - Tips, Bonuses, and Commissions
  - Short Term Disability
  - Pension payments
  - Payments from retirement accounts
  - Lottery winnings disbursements
  - Monthly payments from trust funds
  - Unemployment income
- SSI and SSDI income is not allowed to be counted for minors or adults with disabilities who are still under the care of their parents or guardians.

Income Documentation

- Facilities may NOT require more documentation than is necessary to prove income for a household
- Facilities may NOT require documentation different from what is listed in the Operations Manual
  - E.g. patients are not required to provide an ID to complete the application

Question 4

- Are alimony or child support allowable income sources to be counted?
  - A. Yes
  - B. No

Answer 4

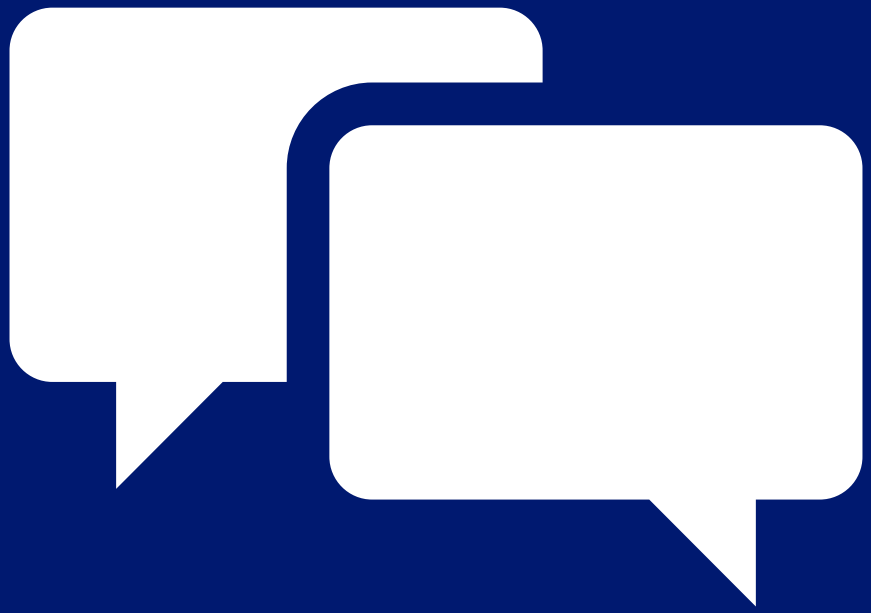
- Are alimony or child support allowable income sources to be counted?
  - A. Yes
  - B. No
- HDC and CICP do not count alimony or child support as income sources.

Deductions

- Hospitals are allowed to count deductions as they see fit for their individual patient populations
  - Deductions must be uniform across all patients and should be spelled out in policy
  - Can be documented or self-declared, based on hospital policy
- Including deductions is completely optional for hospitals

Completing the Application

- Hospitals have 14 calendar days from the date all required documentation is submitted to complete the household's determination and send the determination notice in writing



Questions?

Step 4: Determination Notice

Determination Notice

- Determination notice must be sent in writing within 14 days of the household submitting all required documentation for the application
  - Patients whose determination notices are not sent within 14 days may appeal within 60 calendar days of the patient submitting all required documentation
- Required notice elements vary depending on what the household is found eligible or likely eligible for
- An eligible determination is generally valid for one year from the date of the application whereas an ineligible determination only covers one episode of care

HDC/CICP Eligible

- The programs and discounts for which the patient was determined likely eligible for
  - Additional information and how to apply for each program including deadlines to apply to have services covered
- The dates for which the discounted care determination is valid
- The household size and income used to determine eligibility and the household calculated FPG
- The patient's 4% and 2% limits based on their calculated gross household income

HDC/CICP Eligible (cont.)

- If the patient was applying and approved for CICP, the patient's CICP rating
- If the patient was applying and approved for CICP, the patient's CICP copay cap
- If the Health Care Facility is not a CICP provider, information on where the patient may obtain CICP services
- Information on how to file a complaint and how to file an appeal with the Health Care Facility and the Department, including but not limited to the contact information of the person at the Facility who handles appeals and the Department's Hospital Discounted Care email (hcpf_HospDiscountCare@state.co.us)

HDC/CICP Ineligible

- The basis for denial of discounted care
- The programs and discounts for which the patient was determined likely eligible for
  - This must also include where to find additional information including deadlines to apply to have services covered
- The service date or dates the discounted care denial covers and an explanation that the household may qualify for coverage of future services if there is a change in household size or income

HDC/CICP Ineligible (cont.)

- The household size and income used to determine eligibility and the household calculated FPG
- Information on how to file a complaint and how to file an appeal with the Health Care Facility and the Department, including but not limited to the contact information of the person at the Facility who handles appeals and the Department's Hospital Discounted Care email (hcpf_HospDiscountCare@state.co.us)

Question 5

- Should hospitals include the programs that households are found **not likely eligible** for in their determination notice?
  - A. Yes
  - B. No

Answer 5

- Should hospitals include the programs that households are found **not likely eligible** for in their determination notice?
  - A. Yes
  - B. No
- Hospitals should **not** tell patients they are not likely eligible for anything because this is a very limited screening that may not take into account everything the different programs count or don't count.

Process Timeline

- Patients who communicate an interest in applying for HDC/CICP can start the screening and/or application process at any point between the screening and their bill being sent to collections
  - Collections for patients cannot start until the 182nd day past their DOS/DOD, whichever is later

Billing Timeline

- For patients who choose not to be screened – bill can be sent after the Decline Screening form has been signed or the patient has indicated during Screening Best Efforts that they do not want to be screened
- For patients who complete the screening and choose not to apply – bill can be sent after the screening is completed
- For patients who complete the screening and want to apply – bill can be sent after the application has been completed and the determination notice has been sent
- Bills may not be sent while the patient is in the middle of the screening or application process regardless of when that process begins

Questions?

Additional Training

- Screening and Application Processes
  - April 24, 9:00 to 11:00 a.m.
  - April 27, 1:00 to 3:00 p.m.
- Payment Plans and Collections
  - April 26, 1:00 to 3:00 p.m.
  - May 2, 1:00 to 3:00 p.m.
- Data Template
  - April 27, 9:00 to 11:00 a.m.
  - May 4, 1:00 to 3:00 p.m.
- Q&A
  - May 11, 1:00 to 4:00 p.m.

Office Hours

- Every Wednesday starting at 9:00am
- Meeting link and call-in information available on the Hospital Discounted Care website
- Come with any and all questions about HDC or CICP

Contact Info

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https://hcpf.colorado.gov/hospital-discounted-care

Thank you!