COLORADO
Department of Health Care Policy & Financing

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Hospital Discounted Care Operations Manual

Fiscal Year 2025-26

Section I: Overview and Patient Rights

Article I. HB 21-1198 HOSPITAL DISCOUNTED CARE

Section 1.01 HB 21-1198 Hospital Discounted Care Overview

House Bill (HB) 21-1198, also known as Health Care Billing for Indigent Patients or Hospital Discounted Care, established discounted billing requirements for low-income patients in Colorado.

The law requires all uninsured patients and any insured patient who requests financial assistance to be screened for eligibility for the following programs:

- Health First Colorado (Colorado's Medicaid Program)
- Child Health Plan *Plus* (CHP+)
- Medicare
- Emergency Medicaid
- Hospital Discounted Care
- Hospitals' internal charity care program

Screening Requirement

- Health Care Facilities must screen all uninsured patients for financial assistance unless the patient declines.
- If an insured patient requests financial assistance, the facility must conduct a screening following the procedures in Section II: Eligibility and Screening.

Billing and Payment Limitations

HB 21-1198 established specific rules for Health Care Facilities and Licensed Health Care Professionals regarding the amounts that may be billed, collected, and pursued in collections.

Facilities and professionals must limit billed charges to no more than the discounted rate established under the Colorado Department of Health Care Policy and Financing (HCPF) rules. HCPF ensures discounted rates are no less than 100% of the Medicare rate or 100% of the Medicaid base rate, whichever is greater. HCPF publicly posts these rates on the Hospital Discounted Care Rates website and the rates are updated at least annually each July 1. See Section IV: Billing, Collections and Rates for additional information.

Monthly Payment Limits

Facilities and professionals may collect amounts charged, not including amounts owed by third party payers, in monthly installments such that a qualified patient does not pay more than:

- 4% of monthly gross household income on a facility-only bill;
- 2% of monthly gross household income on a bill from each Licensed Health Care Professional who bills separately; or
- 6% of monthly gross household income on a combined bill that includes both facility and professional charges (per Senate Bill 24-116).

These percentages are maximum limits. Facilities and professionals are encouraged to offer more favorable payment plans that align with their internal policies. See Section IV: Billing, Collections and Rates for additional information.

Payment Completion and Collections

- A patient's bill must be considered paid in full after 36 months of payments, and all collection activities must cease at that time.
- Before initiating any collection actions, the facility or professional must:
    - Complete the required screening as outlined in Section II: Eligibility and Screening;
    - Apply discounted charges for qualified patients;
    - Provide a plain-language explanation of the services and charges, including notice of potential collection actions; and
    - Bill all third-party payers responsible for the patient's coverage.

If a Licensed Health Care Professional is out-of-network under a qualified patient's insurance plan, both the professional and the insurance carrier must comply with out-of-network billing laws in C.R.S. § 10-16-704(3) and § 12-30-113. See Section IV: Billing, Collections and Rates for additional information.

Prohibited Practices

A Health Care Facility must not:

- Deny discounted care because a patient has not applied for a public benefits program, unless during the initial screening the patient is determined to be presumptively eligible for the state medical assistance program; or

- Adopt or enforce policies that deny admission or treatment to a patient because the patient:
    - Lacks health insurance,
    - May qualify for discounted care,
    - Requires extended or long-term treatment, or
    - Has an unpaid medical bill.

Additional Resources:

More information, including current rates and program materials, is available on the Hospital Discounted Care website maintained by HCPF.

Section 1.02 Definitions

A. Billing Statement – Any patient-facing communication, whether electronic or written, that specifies an amount due for services and includes instructions for making payment.

B. Creditable Coverage – Benefits or coverage provided under:

    a. Medicare, the Colorado Medical Assistance Act (Articles 4 to 6 of Title 25.5, C.R.S.), or the Children's Basic Health Plan (Article 8 of Title 25.5, C.R.S.);

    b. An employee welfare benefit plan, group health insurance, or health benefit plan;

    c. An individual health benefit plan;

    d. A state health benefits risk pool; or

    e. Coverage under Chapter 55 of Title 10 (U.S. Code), a medical care program of the Indian Health Service or a tribal organization, a health plan offered under Chapter 89 of Title 5, a public health plan, or a Peace Corps health benefit plan under 22 U.S.C. § 2504(e).

C. Elective Surgery or Elective Procedure – A surgery or procedure scheduled in advance that does not involve a medical emergency.

D. Federal Poverty Guidelines (FPG) – A measure of income level issued annually by the U.S. Department of Health and Human Services (HHS). For Hospital Discounted Care, the FPG is updated annually on April 1 to coincide with the annual Medicaid update.

E. Guardian – A parent, legal guardian, or legal representative.

F. Health Care Facility – A hospital licensed as a general acute or critical access hospital; a licensed free-standing emergency department; an on-campus outpatient facility or department of a hospital; or an off-campus facility operating under a hospital's

license. *Exclusions:* Federally Qualified Health Centers and student-learning medical or dental clinics established for educational purposes within a health sciences school.

G. Health Care Services – Services provided for medical, behavioral, mental-health, substance-use-disorder, dental, or optometric care; hospitalization; or nursing-home care. Includes preventive or therapeutic services and telehealth as defined in C.R.S. § 10-16-123(4)(e).

H. Household – Any person living at the patient's address and any other member living outside the state or country whom the patient or guardian provides **50 percent or more** financial support.

I. Impermissible Extraordinary Collection Action – Initiating foreclosure on an individual's primary residence or homestead, including a mobile home, as defined in C.R.S. § 38-12-201.5(5).

J. Inpatient Hospital Service – As defined in 42 CFR 440.10, services that:

1. Are ordinarily furnished in a hospital for the care and treatment of inpatients;
2. Are furnished under the direction of a physician or dentist; and
3. Are furnished in an institution that—
   (a) Is maintained primarily for the care and treatment of patients with disorders other than mental diseases;
   (b) Is licensed or formally approved as a hospital by an officially designated state authority;
   (c) Meets the requirements for participation in Medicare as a hospital; and
   (d) Has a utilization-review plan meeting § 482.30, unless waived by the Secretary.

K. Licensed Health Care Professional – Any health-care professional registered, certified, or licensed under Title 12, C.R.S., or practicing under the supervision of such a professional, who provides Health Care Services in a Health Care Facility.

L. Medically Necessary – As defined in 10 CCR 2505-10, Section 8.076.1.8, a good or service that:
1. Prevents, diagnoses, cures, corrects, or alleviates illness, pain, or disability;
2. Meets generally accepted professional standards in the United States;
3. Is clinically appropriate in type, frequency, extent, site, and duration;
4. Is not primarily for the provider's or patient's convenience or economic benefit;
5. Is delivered in the most appropriate setting required by the patient's condition;
6. Is not experimental or investigational; and
7. Is not more costly than other equally effective treatment options.

M. Outpatient Hospital Service – As defined in 42 CFR 440.20, services that:
1. Are preventive, diagnostic, therapeutic, rehabilitative, or palliative;
2. Are furnished to outpatients under the direction of a physician or dentist; and
3. Are furnished by a hospital licensed or approved by the state and meeting Medicare participation requirements. A Medicaid agency may limit this definition by excluding items or services not generally furnished by most hospitals in the state.

N. Permissible Extraordinary Collection Action – A legal or judicial process other than an Impermissible Extraordinary Collection Action, including but not limited to:

- Placing a lien on an individual's real property;
- Attaching or seizing an individual's bank account or other personal property; or
- Garnishing wages.

Does not include assertion of a hospital lien under C.R.S. § 38-27-101.

O. Qualified Patient – An individual who resides in Colorado, whose household income is not more than 250% of the Federal Poverty Guidelines, and who has received Health Care Services at a Health Care Facility.

P. Screen, Screening, or Screened – The process by which a Health Care Facility assesses a patient's eligibility for public-health-coverage or discounted-care programs, informs the patient of likely results, and provides enrollment information.

Q. Third Party – Any individual, institution, corporation, or public or private agency that is or may be liable to pay all or part of the medical cost of an injury, disease, or disability for an applicant or recipient of Hospital Discounted Care.

R. Uninsured Patient – An individual who does not have Creditable Coverage.

Article II. PATIENT RIGHTS

Section 2.01 Notification of Patient Rights

HCPF has developed a written explanation of patient rights under House Bill (HB) 21-1198, written in plain language at approximately a sixth-grade reading level. This document is translated into all languages spoken by 10 percent or more of the population in any Colorado county and is available on the Hospital Discounted Care website under the *Forms* section.

A. Minimum Requirements for Health Care Facilities

Each Health Care Facility must:

1. Post the Patient Rights and the Uniform Application (as developed by HCPF)
    - In all required languages; and
    - Conspicuously on the facility's website, including a direct link on the facility's main landing page.
2. Make the Patient Rights information available in patient waiting areas.
3. Provide the Patient Rights information to each patient or their legal guardian:
    - Verbally, which may include the use of a professional interpretation service, or
    - In writing, in the patient's or guardian's preferred language,

- Before the patient leaves the Health Care Facility.

4. Include Patient Rights information on all billing statements, informing each patient of:
    - Their right to apply for discounted care; and
    - The facility's website, email address, and telephone number where this information can be obtained in the patient's preferred language.

A billing statement includes any patient-facing communication, electronic or written, that specifies an amount due for services and provides instructions for payment.

B. Prohibitions

Health Care Facilities shall not:

1. Deny discounted care because a patient has not applied for any public benefits program, unless during the initial screening the patient is determined to be presumptively eligible for the state medical assistance program; or

2. Adopt or maintain any policy that results in the denial of admission or treatment to a patient because the patient may qualify for discounted care.

Section 2.02 Presentation of Patient Rights

The Patient Rights document created by the Department of Health Care Policy and Financing (HCPF) is provided to Health Care Facilities and patients as a two-page, double-sided document.

While this is the standard format, HCPF recognizes that alternative layouts may improve accessibility for patients. Health Care Facilities may reformat the Patient Rights document (for example, into a brochure or similar layout) if approved by HCPF prior to use.

A. Approval Process for Reformatting

1. Any reformatted version of the Patient Rights document must be submitted to HCPF for approval before distribution.

2. Facilities must email reformatted materials to hcpf_HospDiscountCare@state.co.us for review and authorization.

B. Content and Presentation Requirements

- A reformatted document may not alter or omit any information published in the official HCPF Patient Rights document.
- Facilities must not minimize the importance of the Patient Rights content by placing it in footnotes, using smaller font sizes, or otherwise formatting it in a way that reduces visibility or emphasis.