COLORADO
Department of Health Care Policy & Financing

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Hospital Discounted Care Operations Manual

Fiscal Year 2025-26

Section III: Application and Determination Notice

Article I. APPLICATION PROCESS

Section 1.01 Uniform Eligibility Application

Health Care Facilities shall use a single Uniform Application developed by HCPF to determine eligibility for Hospital Discounted Care. The Uniform Application can be completed before or after care is received at the Health Care Facility.

If a patient's self attested screening determines that they likely qualify for Hospital Discounted Care and the patient wants to apply, the patient has 45 days to provide the necessary documentation to complete their application. If a patient appears not to be eligible for Hospital Discounted Care from the initial screening but wishes to complete the full application, the Health Care Facility must allow them to apply. Health Care Facilities should ensure the patient is given instructions on how to submit their documents.

If the patient does not submit all the required documentation within the 45-day time period, they may be asked to resubmit updated documentation that reflects their current income in order for the Health Care Facility to accurately calculate their current household income. Patients have until at least the 181st day past their date of service or date of discharge, whichever is later, to begin the screening and/or application process.

If a patient or household indicates during or immediately after their screening that they want to apply, the facility should attempt to set up an application appointment at the time of the screening. If a facility does not schedule application appointments and instead uses another process for patients to submit their information to complete the application, information on how to submit the necessary documents must be provided to the patient during or after the screening. Best practice would be to provide the information in writing explaining how to submit documentation. This information can be provided either at the time of the screening, or after the screening by email, portal message, or SMS message. Health Care Facilities may accept documents in person, through the mail, via email, facsimile, etc., and are encouraged to have an electronic submission option.

If an application appointment is made during or after a screening and the patient does not show up, the facility must contact the household at least once to reschedule the appointment prior to sending the first bill. If an appointment is not made, the facility must contact the household at least once to schedule an appointment prior to sending the first bill.

If a patient appears eligible for Health First Colorado and/or CHP+ and opts to apply for those programs and not complete an application for Hospital Discounted Care, but then is found to be ineligible for Health First Colorado and/or CHP+, the patient may request to complete the application for discounted care with the Health Care Facility that provided their services. HCPF is aware that there may be some situations where the patient's determination for Health First Colorado/CHP+ may take longer than normal and put the patient outside of the normal application window for Hospital Discounted Care. The patient must be allowed to apply as long as they request to begin the application process within 45 days of the date of their Health First Colorado/CHP+ denial as noted on their denial letter.

A Health Care Facility must provide the patient notice of the determination and an opportunity for the patient to appeal the determination in accordance with CCR (25.5-3-502 (3)).

Section 1.02 Other Facility's Determinations

Facilities are allowed and encouraged to accept ratings from other facilities. This includes accepting income determinations from federally qualified health centers (FQHCs) and federally certified rural health clinics (RHCs). FQHCs and RHCs only include income in their determinations and therefore their calculations are comparable to the Hospital Discounted Care guidelines.

If the income determination is coming from another hospital, the facility only needs to keep a copy of the patient's card issued by the other facility in the patient's record to meet the screening and application requirements.

If the income determination is coming from an FQHC or an RHC, the facility will need to transfer the patient's household information into the Uniform Application. The facility will need to contact the FQHC or RHC and request the patient's calculated monthly or annual household income as well as determine if any additional household members were included in the application that do not appear on the patient's clinic issued card or rating determination notice. These two pieces of information are needed to ensure the rating and monthly maximum amounts are calculated correctly when the facility enters the information into the Uniform Application.

Facilities must also keep a copy of the patient's clinic issued card or rating determination notice with the Uniform Application as documentation of the information used for their determination. Additionally, information on when the original issuing provider was contacted, including the date, time, and the name of the person that gave the patient's information, must be documented in the Uniform Application.

If a patient completes an application and then later presents a determination from another Health Care Facility that contradicts the first facility's determination, the facility is not required to accept the determination from the other facility. If the patient states that there was a change in household size or income that was factored into their second determination, they would be allowed to complete a new application or permit the facility to reach out to the second facility to request a copy of the application the second facility completed.

Section 1.03 Acceptable Documentation for the Uniform Application

A Health Care Facility may request the following information and documents to establish current financial income eligibility for discounted health care based on the most recent month's income:

- First and last name, address, contact information (e.g., email, phone), and birth date for the applicant and any other household members included in the application
- Employer and income information for each working adult household member
    - For employed household members, excluding those who work exclusively jobs for cash, either
        - Paycheck stubs, payroll history, or other wage records, or
        - A letter from their employer stating their salary or hourly wage and usual number of hours worked per pay period, or
        - Most recent tax return, or

        - The eligibility technician may contact the employer to get verbal confirmation of the household member's pay. Documentation of who was contacted, their contact information, and the pay information they supplied must be kept within the patient's application.
    - For self-employed household members, either
        - Paycheck stubs, payroll history, or other wage records if they pay themselves as an employee of the business,
        - Business financial records, including but not limited to profit and loss statements, ledgers, business bank accounts showing deposits and withdrawals, invoices and receipts, etc. (Patients do not need to provide all of these documents, just enough to show their monthly income) if they do not pay themselves as an employee of the business, or
        - Most recent tax return, if the household member does not have an available record of more recent business income and expense activity.
    - Household members who work jobs for cash must provide
        - Bank receipts showing cash deposits made, or
        - Ledgers (account book, list of income and expenses, etc.) or other documentation of payments from clients, or
        - Letters from their employer (i.e. stating how much they normally pay them for their services in a month), or
        - If the patient is unable to provide any of the documents above they may self-declare their income either verbally or in writing.
- For household members receiving unemployment benefits, their unemployment benefit 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.

When calculating income, the Health Care Facility shall obtain the minimum amount of documentation to substantiate amounts and may not mandate that patients provide a specific document type listed above as all are acceptable. Patients that are unable to obtain any of the acceptable documents listed above may self-declare their income either verbally or in writing.

Patients who are experiencing homelessness are exempt from the documentation requirements and are allowed to use self-attested information for both the screening and the application for discounted care.

Section 1.04 Determining Patient Income

HCPF categorizes income into three categories. These categories are:

- Employment (Earned) Income
- Unearned Income, and
- Self-Employment

When calculating income, the Health Care Facility shall obtain the minimum amount of documentation to substantiate amounts. If a patient attests to their income verbally, the facility needs to ensure that information is included in the notes section of the Application tab in the Uniform Application for auditing purposes.

Section 1.05 Employment (Earned) Income

Employment income is income earned (including overtime, bonuses, tips, and commissions) for providing services to another individual or company. Earned income from a working minor (under the age of 18) or an adult student living with their parents or guardians is not included in the household income calculation for Hospital Discounted Care. Adult students applying on their own must include any income in their application. Employment income for Hospital Discounted Care does not include self-employment income which is addressed separately, unless the household member pays themself as an employee of the business. See Section 1.03 for documentation requirements.

For household members who receive pay stubs, questions related to the household member's pay stub that the household member cannot answer, including but not limited to their pay period, how many paychecks they have received for the year, etc., should be verified by the applicant's employer either in writing or over the phone. Health Care Facilities should record the name of the enrollment staff that called, who they spoke to, what the position is of that person (manager, HR, etc.), and the time and date of the phone call in the notes section of the application.

There are three steps to calculating current employment income.

Step 1. Obtain documentation for most recent months' employment income. If the household member provides a paystub that shows their year-to-date pay, only one paystub would be needed. The determination process looks at the financial circumstances of a household as of the date an application is started. If an applicant has just started a new job and has less than one month's worth of pay stubs, or has not received a paycheck yet, facilities may use one of the other verification methods specified in Section 1.03 to collect information to calculate the applicant's monthly income and convert to an annual income. HCPF recommends calculating the monthly income using the Year-to-Date Method as described below. Complete Worksheet 1 – "Earned and Unearned Income" using gross amounts. "Gross" means the dollar amount before any deductions or losses are subtracted.

Step 2. Use one of the following methods to determine the monthly gross employment income.

Year-to-Date Method:

The Year-to-Date Method of calculating annual gross income uses the applicant's year-to-date gross earnings on the most current year-to-date pay stub. For this method, only one pay stub would be needed. To determine the annualized income, count the number of paychecks that have occurred since January 1, and then divide that number into the gross year-to-date earnings stated on the pay stub. Enter the total year-to-date earnings, the pay period type, and the number of paychecks received since January 1 into the appropriate lines of the Year-to-Date Methodology calculation box in the Worksheet 1 tab of the Uniform Application. The Uniform Application will use these three pieces of information to determine the annualized gross earnings. If the applicant has not been at their job since January 1 but it can be determined how many paychecks they have received for the year, this method can still be used.

Example: The applicant provides a recent pay stub showing year-to-date earnings of $13,756. The pay frequency is bi-weekly. The pay period ended September 30th and since January 1st the applicant has been paid 19 times. The calculation would be as follows:

Divide $13,756 by 19 bi-weekly pay periods = $724.00

Multiply $724 by 26 bi-weekly pay periods in a year = $18,824

Average Pay Method:

The Average Pay method of calculating income uses the average gross earnings based upon the number of pay stubs provided. When using this method, HCPF recommends that the facility obtain at least a full month of pay stubs from the applicant. To determine the average gross earnings, choose the correct pay period type from the dropdown box and enter the gross earnings of all the pay stubs provided into the Average Pay Methodology calculation box in the Worksheet 1 tab of the Uniform Application. The Uniform Application will automatically convert the average gross earnings to monthly income.

Unless the applicant is paid semi-monthly DO NOT add up all the paychecks for the month and multiply by 12 to calculate the applicant's annual income. This will either understate or overstate the applicant's income depending on the pay frequency and month.

Example: An applicant provides six pay stubs with gross earnings of $534.00, $475.00, $398.00, $534.00, $498.00 and $534.00. The pay frequency is weekly. The calculation would be as follows:

Add: $534.00, $475.00, $398.00, $534.00, $498.00, and $534.00 = $2,973.00

Divide: $2,973.00 by 6 pay stubs = $495.50 average weekly gross earnings

Multiply: $495.50 by 4.333 = $2,147.00

Multiply: $2147.00 by 12 months = $25,764.00

Example: The applicant is paid every two weeks and has received only one paycheck, totaling $200. The calculation would be as follows:

Monthly gross earnings = $200 x 2.1666 = $433.32 per month

Annual income = $433.32 x 12 months = $5,199.84 per year

Example: If the applicant has just started a job but has not received a paycheck yet, a letter from the applicant's employer is allowable. Use the information in the letter to calculate the monthly income using the Average Pay Method. The calculation would be as follows:

Letter from the employer with hourly wage and hours to be worked per week:

Weekly earnings = $15.00 per hour x 20 hours per week = $300 per week

Monthly gross earnings = $300 x 4.333 = $1,299.90 per month

Annual income = $1,299.90 x 12 months = $15,598.80 per year

Monthly Pay Method:

Note that this method is only accurate for applicants with fixed salaries. Employees paid monthly on an hourly basis will likely have paychecks that vary in amount month to month. The monthly pay method of calculating income utilizes the most recent monthly pay stub.

Step 3. Enter the calculated monthly income from Step 2 next to the appropriate household member in the Combined Earned Monthly Gross Income box in Worksheet 1 of the Uniform Application. Repeat for all appropriate household members.

Section 1.06 Self-Employment Income

If a self-employed household member pays themselves just as they would their employees, and can document by pay stubs, enter the figure from the pay stub into Worksheet 1 as you would for any other employment income. This can also be done for household members who "pay" themselves by transferring money from their business account to their personal account, as long as they file a 1099 with their taxes. In these cases, Worksheet 2 would not need to be completed. For a self-employed household member who does not pay themselves in either of these ways, Worksheet 2 must be completed and attached to the application.

To determine the net profit of a self-employed household member, deduct the cost of doing business from the gross income. To obtain the gross income, request documentation from the list in Section 1.03 for self-employed household members. Household members may not write down income and expenses while at the rating appointment without providing acceptable documentation of the income and expenses. Gross income amount and business expenses listed on the accepted documentation should be transferred to Worksheet 2. An expense is something that is necessary to keep a business in operation.

Self-employment expenses must not include:

- Depreciation of equipment.
    - Depreciation is included in expenses when doing business taxes. If you are using a patient's business taxes you must add the depreciation amount back in.
- Cost of payment on principal of loans for capital assets, or durable goods.
- Personal income tax payments, lunches, transportation to and from work, and other personal expenses.

For businesses that are operating out of the home, determine what portion of household expenses should be attributed to the business. For home expenses that can be used for personal and business purposes, designate a percent for the amount of time that a particular expense is used for the business.

Example:

A subcontractor works out of his primary residence. The subcontractor's gross monthly income is $2,000. Eight hundred square feet of the 2400 square foot home is for the business and the household member runs their business for 60 hours of the week. Other household activities occur in the business space when the household member is not working. This information should be entered into the appropriate lines at the top of Worksheet 2 so that the correct percentage of the Business Property Expenses can be calculated.

The household expenses and business portions of those expenses are as follows:

- Mortgage $900 - Subcontractor works from primary residence, enter $900 in the Mortgage/Rent of Business Property line in the Business Property Expenses section of Worksheet 2. The Uniform Application will use the entered information about the square footage of the residence and business space, and the hours the space is used for business to calculate the amount of the mortgage that can be used as a business expense.

- Utility $100 - Subcontractor works from primary residence, enter $100 in the Utilities line in the Business Property Expenses section of Worksheet 2. The Uniform Application will use the entered information about the square footage of the residence and business space, and the hours the space is used for business to calculate the amount of the utilities that can be used as a business expense.

- Internet $45 - Subcontractor uses 75% of the internet for the business. $45 multiplied by .75 = $33.75. Enter $33.75 as the business expense for the internet in the Other Expenses section of Worksheet 2.

- Phone $50 - Subcontractor has a separate business telephone. Enter the entire expense for business purposes in the Other Expenses section of Worksheet 2.

- Supplies $60 - Subcontractor only uses supplies for business purposes. Enter the entire expense for business purposes in the Other Expenses section of Worksheet 2.

For this example, Worksheet 2 should reflect a monthly gross profit of $1,737.20, annualizing to $20,846.43.

Section 1.07 Short Term Disability Income

Households with members who are on short-term disability are unique cases and should be treated as such. For clarification, short-term disability income should only be counted if the household member is currently or will soon be receiving payments. If the household member received short term disability earlier in the year but is back to being employed full time, that income should not be considered as part of their income determination going forward since they are no longer receiving it. Hospital Discounted Care looks at the household's current situation and calculates the next 12 months (365 days) using that information. As such, it would be inappropriate to include income that is no longer being collected.

Short-term disability is temporary and only pays a percentage of normal income, so rating a household for a full year using this income would be incorrect, as would rating them using their normal income. Instead, income for these household members should be calculated using a combination of both. For example, if the household member is being paid bi-weekly and will be on short term disability for six weeks, their income should be calculated using the six weeks of short-term disability pay and using 23 bi-weekly pay periods of their normal income. Using 23 bi-weekly pay periods accounts for 46 weeks of the year, and the six weeks of short-term disability makes up the remaining weeks for the full 52-week year.

To enter this into the application correctly, calculate the total amount the applicant expects to be paid through their normal employment over the next 12 months and enter that figure divided by 12 next to the household member's name in the Combined Earned Monthly Gross Income box. In the case of the example above, you would be looking at 23 bi-weekly pay periods of income over the following 12 months. Next, enter the full amount of the remaining payments the applicant will receive from their Short Term Disability into the Short

Term Disability line under the Annual or One Time Unearned Income Sources section. The combination of these two incomes, employment and Short Term Disability, should cover the full 52 week year.

Documentation must be collected for households collecting Short Term Disability payments to support their income calculation.

Section 1.08 Unemployment Benefits

Households with members who are receiving unemployment benefits are unique cases and should be treated as such. For clarification, unemployment benefits should only be counted if the household member is currently receiving them. If the household member received unemployment benefits earlier in the year but the benefit has run out, that income should not be considered as part of their income determination going forward since they are no longer receiving it. Hospital Discounted Care looks at the household's current situation and calculates the next 12 months (365 days) using that information. It would be inappropriate to include income that is no longer impacting their situation.

Unemployment is temporary and has a maximum payable amount. An individual drawing unemployment can only collect money as long as they have money in their unemployment account. Individuals who are collecting unemployment are informed of the maximum payment amount, so the number of remaining weeks they will be able to claim unemployment funds can be easily calculated. Households with members who are currently drawing unemployment funds should only be rated for the period of time that the unemployment benefit will cover. Once this period is over, the household should be rerated as their income will have changed, whether they've secured a new job or have no other income at all. Health Care Facilities are not required to automatically perform a redetermination for these households, the household will be responsible for contacting the facility if they wish to be redetermined.

Documentation must be collected for households collecting unemployment benefits to support their income calculation.

Section 1.09 Tax Returns

Households may use their most recent tax return if there is no other documentation they can provide that is more recent, or if their income situation is best shown in an overall annual way. This can be true in a variety of situations, including if a household member works only seasonal jobs, if a self-employed household member has extremely varied income month to month or season to season (e.g., farm workers), along with other various situations. Health Care Facilities should always take the household's situation into account when determining how to calculate their income. Tax returns should not be used for households whose income situation has changed since the year the taxes cover. For example, a patient who has changed jobs or had a change in their hours or pay should use documentation that shows their current income.

When using tax returns, facilities should not take into account the federal standard deduction from the calculated income. That deduction is for tax purposes only and does not factor into income calculation for Hospital Discounted Care.

Section 1.10 Additional Deductions

Health Care Facilities may make additional deductions to a household's income determination based on existing, new, or updated policies at their facilities. HCPF recognizes that Health Care Facilities are well versed in the needs of their individual communities, and that what one facility considers an important deduction for their patients may not make sense for another facility. Deductions can be included in the Uniform Application on Worksheet 3. Health Care Facility deduction policies must be documented in order to be available for auditing purposes.

The Card Template tab within the Uniform Application has been coded to notate if deductions were included in a household's determination. If deductions were included, the card shows what the household's rate would be without the deductions. This was added so that facilities that do not count deductions but are accepting determinations from other facilities who do count deductions can clearly identify when deductions were used. The facility can then determine if they want to have the patient fill out a new application with their facility due to differing deduction policies.

Section 1.11 Spend Down

Some households may be determined to be just slightly over income to qualify for Hospital Discounted Care. The Application tab of the Uniform Application has a built-in calculation to the right of the section that shows the household's calculated FPG that will show how much over income the household is. Health Care Facilities may allow the household to pay the amount they are over income toward their current bill and use that payment as a deduction in order to qualify for Hospital Discounted Care. The amount the household pays towards the bill would be entered in Worksheet 3 as a deduction, and should be clearly labeled as a spend down. If this spend down is allowed, the amount the household paid towards their bill in order to become eligible would be counted as a third party payment and they could set up a payment plan for the remainder of their allowable amount due. If the spend down is used, notes should be kept in the application so that it is clear what occurred should the application be pulled for an audit.

Section 1.12 Determination and Redetermination

A determination is not considered to be complete until all required documentation has been provided by the patient or guardian and the Health Care Facility has calculated their household FPG using the Uniform Application. The Health Care Facility must calculate the household FPG and inform the patient of the determination within 21 calendar days of receipt of all required documentation. Health Care Facilities are responsible for informing all Licensed Health Care Professionals who provided services to the patient at the Health Care Facility of the patient's determination outcome, as well as any changes to a patient's eligibility or income calculation due to an appeal made by the patient challenging the Health Care Facility's determination. See Section 2.04 Notification of Licensed Health Care Professionals within this Section III for more information. A patient may also provide notice of their discounted care determination to the Licensed Health Care Professional and, whether the Licensed Health Care Professional received the notice from the Health Care Facility or from the patient, the Licensed Health Care Professional must accept the determination notice as conclusive evidence of the patient's eligibility for discounted care.

An eligible determination is generally valid for one year from the date of the application, which should match the date the application was started, or the first date of service the application is being completed to cover, whichever is earliest. Patients may apply to cover

services within 181 days of the date of the application, and both Health Care Facilities and Professionals are allowed to extend determination validity based on their own internal policies. Professionals are not required to apply Hospital Discounted Care to accounts outside of the standard 181 day backdating period, regardless of whether the Health Care Facility approved a longer backdate for accounts at the facility.

Determinations may be made for a shorter amount of time in specific situations:

- Households with a member who is currently receiving unemployment benefits will have their eligibility automatically end dated by the Uniform Application to match when their benefit ends, as there will always be a change in the household's FPG calculation at that point.
- Households that have recently had one or more members become eligible for Health First Colorado and/or CHP+ can apply to cover only dates of service prior to their Health First Colorado/CHP+ eligibility that will not be covered by those programs.
- Households who received services while Colorado residents who have since moved out of state can apply to cover only dates of service while they were living in Colorado.
    - Similarly, Health Care Facilities that allow non-residents to apply can approve the determination for a specific date or date range.

An ineligible determination is only valid for the dates of service the patient is applying to cover. Uninsured patients who are determined ineligible will need to be screened or sign a Decline Screening form if they seek new services unrelated to previous episodes of care after their application has been completed.

HCPF does not have stipulations on when a patient may request to begin a renewal of their expiring determination. It is left up to the facilities to determine when patients would be allowed to begin a new application to cover the 12 months following the expiration of their current determination. However, it would be expected that patients would not have a gap in effective dates between the end of the current determination and the beginning of the new determination.

Health Care Facilities must complete a redetermination for any patient or guardian who requests one at any point during the patient's established payment plan, or if they receive additional unrelated services either before or after their original determination expires. A Health Care Facility or Licensed Health Care Professional may not increase a patient's established payment plan amount if their redetermination results in a higher FPG. If a patient's redetermination results in a lower FPG, a facility or professional may need to lower the monthly payments in order to comply with the 4% limit for bills from a Health Care Facility that contains only facility charges, the 6% limit for bills from a Health Care Facility that contains both facility and professional charges, or the 2% limit for bills from each Licensed Health Care Professional who bills separately from the Health Care Facility. Facilities and professionals may not add months to a patient's established payment plan. For example, if a household's original determination set their 4% monthly amount to $100 and their redetermination sets their 4% monthly amount at $80, the remaining payments in their payment plan must be lowered to $80. If the household had 18 payments left on their plan, their remaining amount due would change from $1,800 (18 x $100) to $1,440 (18 x $80). The household's payment plan may not be altered in any way to collect the $360 difference in the two calculations.

Article II. NOTICE OF DETERMINATION

Section 2.01 Process for Determination Notice

A Health Care Facility shall determine the patient's eligibility for Hospital Discounted Care and send the determination notice within 21 calendar days of all required documentation being provided by the patient or their guardian. The Health Care Facility shall send the patient written notification in the patient or guardian's preferred language explaining the determination. The written notice of determination should be sent to the patient or their guardian through the patient's preferred method of communication.

Health Care Facilities cannot officially deny a household's eligibility without a completed application, and should not send determination notices to patients stating they have been denied due to missing documentation. Letters may be sent notifying the household that their application cannot be completed without the missing documentation and should include what is missing, when it needs to be submitted, and how the household can submit it.

Similarly, households that are above 250% FPG but fall within the facility's internal charity care limits may not be sent a determination notice only stating their approval for the internal program. All households who are determined to be over income for Hospital Discounted Care must be sent a determination notice including all required elements listed under Section 2.03 Notices for Ineligible Households below. Facilities may include the household's eligibility status for the internal charity care program within the Hospital Discounted Care determination notice so that only one determination notice is being sent.

Section 2.02 Notices for Eligible Households

For households determined to be eligible for discounted care, the determination notice must include but is not limited to:

- List names of all household members included in the Uniform Application and what program and/or discount they were approved for.
- The programs and discounts for which the patient was determined likely eligible for, including but not limited to Medicaid, Emergency Medicaid, CHP+, Medicare, and Hospital Discounted Care, and the availability of subsidies through Connect for Health Colorado. This must also include where to find additional information and how to apply for each program the patient was determined likely or potentially eligible for.
    - If the patient appears likely or potentially eligible for a program and there is a deadline by which the patient must apply for that program in order for their services to be covered, that date must be included in the determination notice.
- The dates for which the Hospital Discounted Care determination is valid.
- The date of the application.
- The household size and income used to determine eligibility and the household calculated FPG.
- The patient's 4%, 6%, and 2% limits based on their calculated gross household income.
- Information on how to file a complaint and how to file an appeal with the Health Care Facility and HCPF, including but not limited to, the contact information of the person at the Facility who handles appeals and HCPF's Hospital Discounted Care email (hcpf_HospDiscountCare@state.co.us).

If the facility has additional charity care programs at locations that do not fall under Hospital Discounted Care that the household also qualifies for, that information can be included in the determination notice as well. All other required information as noted in this section must be included in the determination notice.

Section 2.03 Notices for Ineligible Households

For households determined not eligible for discounted care, the determination notice must include but is not limited to:

- The basis for denial of Hospital Discounted Care.
- List names of all household members included in the application and what program and/or discount they were denied for.
- The programs and discounts for which the patient was determined likely eligible for, including but not limited to Medicaid, Emergency Medicaid, CHP+, Medicare, and Hospital Discounted Care, and the availability of subsidies through Connect for Health Colorado. This must also include where to find additional information and how to apply for each program the patient was determined likely or potentially eligible for.
    - If the patient appears likely or potentially eligible for a program and there is a deadline by which the patient must apply for that program in order for their services to be covered, that date must be included in the determination notice.
- The service date or dates the Hospital 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.
- 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 HCPF, including but not limited to the contact information of the person at the Facility who handles appeals and HCPF's Hospital Discounted Care email (hcpf_HospDiscountCare@state.co.us).

If the household is over income for Hospital Discounted Care but qualifies for the facility's internal charity care program, that information can be included in the household's determination notice. Similarly, if the household is over income for both Hospital Discounted Care and the facility's internal program, that information can all be included in the same determination notice. All other required information as noted in this section must be included in the determination notice.

Section 2.04 Notification of Licensed Health Care Professionals

It is the responsibility of the Health Care Facility to inform any Licensed Health Care Professionals who provided services to the patient at the Health Care Facility of the patient's screening, application, and determination status so that the Professional knows when they may begin the processes of billing and contacting the patient to set up their payment plan. The Health Care Facility must set up a process with the Licensed Health Care Professionals who work within their facility to send reports of patients who have been screened or declined to be screened, patients who are completing or have completed the application process, and the determinations for those patients. These reports can be sent on a schedule agreed upon by the facility and professional, but should be no less frequent than

bi-weekly to ensure timely communication of patient eligibility status. Additionally, the facility may utilize their Electronic Health Record (EHR) system to communicate screening and application status to Licensed Health Care Professionals who provide services to the facility's patients and who have access to the facility's EHR. Facilities who opt to go this route must clearly communicate with their Licensed Health Care Professionals exactly how to access the information and make it clear within the patient's record in the EHR.

This communication responsibility includes informing professionals of any redeterminations made for the patient, due to a newly completed application or patient appeal, including the updated FPG, 2% calculation, and effective dates. This notification should be made at the same time the patient is notified.

Health Care Facilities must ensure that any additional Licensed Health Care Professionals who provide services to the patient at the Health Care Facility are notified of the patient's eligibility for discounted care if the patient seeks additional services during the time period their determination is valid.

Licensed Health Care Professionals are not required to honor backdates longer than 181 days prior to the date of the patient's application. As such, Professionals must be informed of the patient's application date so they can determine what date they are required to backdate to.

Section 2.05 Determination Card for Patients

Included in the Excel version of the Uniform Application is a tab containing a template for a card that can be issued to patients showing their FPG determination, their 4% and 2% monthly maximum payment amounts, their eligibility dates, and the qualified household members. Health Care Facilities are welcome to use this template if they wish to issue cards to patients to make it easier for the facility when the patient is seen again during their eligibility period. Facilities are also welcomed to create their own cards. If a facility opts to create their own cards, the cards must at a minimum include the patient's calculated FPG, the effective dates of the determination, the household 4% and 2% limits, and the qualified household members. The cards can also include the patient's eligibility for the facility's own internal charity care program so that one card may be used for all patients who receive an eligibility determination from the Health Care Facility. Issuing cards to patients who are determined eligible for Hospital Discounted Care is not mandatory but may be helpful for the facility, the Professionals, and the patient.

Section 2.06 Determination Portability

Health Care Facilities are allowed and encouraged to accept determinations from other facilities. If a facility accepts another facility's determination, a copy of the patient's determination notice or card must be included in the patient's record for auditing purposes.

When accepting a determination from another facility, facilities should apply that determination to any account that falls within the effective dates listed on the card. Best practice would be to apply it to anything within at least the previous 181 days if that time period extends back further than the effective date listed on the card. As an example, a patient had services at Hospital A on February 28, and the patient presents a card from Hospital B on June 15. The card has an effective date of March 12. Hospital A can accept this card for the services provided on February 28, as that date is within 181 days of the date the

patient presented the card, and therefore the 181-day backdating period would have covered the date of service in question had the full backdating period been utilized. Hospital A should keep notes about why the card was accepted to cover a date not included in the effective date range for auditing purposes. It is best practice for the facility to check the Provider Portal to ensure the patient did not have active Health First Colorado/CHP+ for the date of service in question.

Health Care Facilities are allowed to include deductions to patient household income based on their internal policies, and therefore a patient's determination may vary from facility to facility. The card template in the Uniform Application will notate whether the determination includes deductions and, if so, what the household FPG would be without the deductions. Facilities may contact a facility that has previously made an eligibility determination for a patient to request the patient's application and supporting documentation with the permission of the patient. Facilities would be able to use the patient's previous application to complete their own determination for the patient that includes different deductions depending on the facility's deduction policies. If a facility uses a Uniform Application and documentation from another facility, the end date of the patient's eligibility at the second facility must match the end date of the patient's eligibility at the first facility. The start date for the second facility would be the earlier of the date of application or date of service the application is being completed to cover.

For example, the patient's card from Hospital A had validity dates September 25, 2022 through September 25, 2023. The patient received services at Hospital B on February 23, 2023. Hospital B opts to contact Hospital A to obtain the patient's documentation to complete an application for their facility because their deduction policy is different than that of Hospital A. The card from Hospital B would have an effective date of February 23, 2023 to match the date of service, and an end date of September 25, 2023, maintaining the original year of validity from their application with Hospital A.