COLORADO
Department of Health Care Policy & Financing

303 E. 17th Ave. Suite 1100
Denver, CO 80203

Hospital Discounted Care Operations Manual

Fiscal Year 2025-26

Section IV: Billing, Collections, and Rates

Article I. BILLING

Section 1.01 Timing of Patient Bills

Bills must not be sent to uninsured patients during the time period the patient is waiting to be screened or is actively completing the Hospital Discounted Care application, which can begin at any point within at least 181 days of the later of the patient's date of service or date of discharge. A patient is no longer considered "actively completing an application" if they have not submitted all of the required documentation within 45 calendar days of starting the application process. The billing departments for the Health Care Facility and Licensed Health Care Professional may send the patient's first bill on or after the earlier of 46 days past the date or service/date of discharge or:

- For patients who choose not to be screened, after a signed Decline Screening form has been obtained or the patient has otherwise informed the Health Care Facility that they do not wish to be screened during the Health Care Facility's completion of the Screening Best Efforts.
- For patients who complete the screening and choose not to apply, after the screening has been completed.
- For patients who complete the screening and want to apply, after the application has been completed and the patient has been notified of the determination.

In the event that the patient has not been screened, has not set up a screening appointment, and has not signed a Decline Screening form, the facility or professional may begin sending bills beginning 46 days after the patient's date of service or date of discharge, whichever is later. Professionals may not bill any uninsured patient prior to day 46 unless they have received confirmation from the facility that the patient has been screened, declined to be screened, or has a current Hospital Discounted Care determination. Professionals should do their due diligence to confirm screening and/or application status with the facility prior to sending the patient's first bill. Facilities and professionals may provide a bill to a patient who requests one prior to the 46th day past their date of service or date of discharge, whichever is later, and should document this request within the patient's file for auditing purposes.

Section 1.02 Charge Amounts versus Billed Amounts

Health Care Facilities and Licensed Health Care Professionals are not to bill patients more than the rates set by HCPF, but should use their normal rates in any instance where their normal rate is less than the Hospital Discounted Care rate. Facilities and professionals are allowed to continue using their normal charges in write off amounts for reporting purposes - see Section VII: Data Reporting. This applies to both reporting under Hospital Discounted Care and for other charity care purposes.

The allowable billed amounts may be higher than what a patient may pay on the payment plans determined by their household income. Facilities and professionals are allowed to include the difference in the lower of the allowable billed amount and the patient's established payment plan in their write off amounts as well. For example, if the normal charge for an uninsured patient's inpatient stay is $10,000, and the allowed rate is $6,000, the hospital would write off the $4,000 above the allowed amount for the eligible patient. Additionally, if the household's maximum monthly payment is $150, their maximum payment

plan would be $5,400 ($150 x 36 months = $5,400) so the hospital would need to write off the additional $600 either before or after the payment plan has been completed.

Section 1.03 Related Charges and Episodes of Care

The definition of "episode of care" is determined by the facility or professional. Health Care Facilities must use the same definition of episode of care for both the creation of payment plans and for the Screening process. In other words, anything that the facility would put under one payment plan would be covered by one Screening/Decline Screening form and vice versa.

For the purposes of billing and setting up payment plans, HCPF considers at a minimum that all services provided to a patient that are related to the same event to fall under one service episode. This means that the patient would only need to be screened once for all the related services and their payment plan would apply to all of the bills for the related services.

For example, if a patient had a heart attack and went to the emergency room and was scheduled for a follow up visit at the hospital the next week to monitor how they were recovering, both the emergency room visit and the follow up visit at the hospital would be considered one episode of care and would fall under the same payment plan. Similarly, if the same Licensed Health Care Professional saw the patient both in the emergency room and at their follow-up visit within the hospital, both dates of service would be considered one episode of care. If the follow up visit was conducted in the Licensed Health Care Professional's own location outside of the hospital, that visit would not fall under Hospital Discounted Care. If the patient had a second heart attack a few months later, that would be considered a separate episode and would fall under a new screening, billing, and payment plan.

In the situation where two or more household members receive services related to the same incident - a car accident, for example - the services provided to each household member could be considered separate episodes of care. Facilities and professionals are encouraged to work with households in these types of situations to ensure they are able to afford their monthly payments to cover all payment plans related to the incident.

Section 1.04 Third Party Payments

Health Care Facilities and Licensed Health Care Professionals must bill a patient's health insurance or other third party who is responsible for the patient's health care, even if the insurance is out of network. Third parties must be billed prior to sending a bill to the patient showing the portion of the bill they are responsible for. Patients must allow the facility and/or professional to bill their health insurance in order for the date(s) of service to be eligible for discount under Hospital Discounted Care.

If an insured patient has not yet been screened, they have at least 181 days from their date of service or date of discharge, whichever is later, and at least 45 calendar days from the date of the bill after the insurance adjustment to request to be screened. Health Care Facilities have three business days to respond to the request and set up a screening appointment.

If an eligible patient is insured or has another third party that is responsible for payments, the allowable billed amount would be the lesser of:

- the rate set by HCPF less any payment from the insurance company or third-party payer,
- their insurance copay and/or deductible, or
- the rate set by HCPF.

If a patient's insurance or other responsible third-party makes a payment on their behalf, and that payment is equal to or exceeds the rate set by HCPF, the patient would not owe anything additional on their bill. Facilities and professionals should not take contractual adjustments into account when determining what the patient would owe, only the amount that they actually receive as payment from the insurance or third-party payer. See below examples:

Example 1: Insurance pays more than HCPF rate:

Normal charge amount:	$1,000
HCPF set rate:	$700
Insurance adjustment:	$100
Insurance payment:	$800
Patient insurance copay:	$100
Amount collectable from patient:	$0
Total payments collected:	$800

Example 2: Insurance copay is more than HCPF rate minus insurance payment:

Normal charge amount:	$1,000
HCPF set rate:	$700
Insurance adjustment:	$250
Insurance payment:	$550
Patient insurance copay:	$200
Amount collectable from patient:	$150
Total payments collected:	$700

Example 3: Insurance copay is less than HCPF rate minus insurance payment:

Normal charge amount:	$1,000
HCPF set rate:	$700
Insurance adjustment:	$350

Insurance payment:	$550
Patient insurance copay:	$100
Amount collectable from patient:	$100
Total payments collected:	$650

Payment plans for patients who qualify for Hospital Discounted Care and have insurance or another responsible third-party payer must follow the 4%/6%/2% limits. See Article II for more information on payment plans.

Section 1.05 Health Sharing Ministries or Medi-Share Plans

Under Hospital Discounted Care, patients who are part of a Health Sharing Ministry, also known as Medi-Share, and lack other health coverage are considered uninsured. Facilities and professionals may continue to enter into one-time contracts with Health Sharing Ministries to collect payment for a covered patient. Facilities and professionals may send patients who are part of a Health Sharing Ministry their bills and may allow patients to set up payment plans prior to receiving a payment or determination from the Health Share. If a payment is received from the Health Share, the patient's bill must be reduced by the amount of the payment and if any over payment has been made by the patient, the overpayment must be returned to the patient.

Section 1.06 Households with Health First Colorado Members

It is common for households that qualify for Hospital Discounted Care to have one or more members that are covered under Health First Colorado or CHP+. It is best practice for facilities and professionals to check the Health First Colorado/CHP+ coverage for household members each time they receive services to ensure their coverage is still active. Households with members who have lost Health First Colorado/CHP+ coverage will need to have those members added to active Hospital Discounted Care and/or facility charity care eligibility.

If there have been no changes in household size or income, there is no need for a new application to be completed. This situation can occur, for example, when a child within the household ages out of CHP+ coverage or if the household obtains private health insurance, ending their eligibility for CHP+. If there has been a change in household size or income that caused the change in coverage, a new application should be completed to add the household member to Hospital Discounted Care coverage. The household has the option to decline to complete a new application, which would maintain coverage for the currently covered members through their expiration date but not cover the member(s) who lost Health First Colorado/CHP+ coverage.

Article II. PAYMENT PLANS

Section 2.01 General Rules for Payment Plans

Health Care Facilities and Licensed Health Care Professionals must allow for qualified patients to set up payment plans for their medical bills under Hospital Discounted Care. Patients are not allowed to be sent to outside institutions to obtain loans to pay off their medical bills in lieu of setting up a payment plan directly with the Health Care Facility or

Licensed Health Care Professional. This includes loans from banking institutions and other creditors, like CareCredit. Third party companies who agree not to charge interest and abide by all Hospital Discounted Care rules related to billing, payment plan creation, including maximum monthly amounts and length of payment plans, and collections processes may still be used.

Payment plans for bills for qualified patients must not exceed 4% of their monthly household gross income on bills from Health Care Facilities containing only facility charges and must not exceed 6% of their monthly household gross income on bills from Health Care Facilities containing charges for both facility and Licensed Health Care Professionals. Payment plans must not exceed 2% of the patient's monthly household gross income for bills from each Licensed Health Care Professional who bills separately from the Health Care Facility. Payment plans may be established for less than the 4%/6%/2% limits.

Payment plans may not exceed 36 months but may be made for a lesser amount of time, provided the monthly payments do not exceed the 4%/6%/2% limits described above.

The 4%/6%/2% limits are maximums. If a facility or professional wants to allow a patient to have a more generous payment plan, or if a facility or professional has current, new, or updated policies that set lower limits for patient payment plans or completely write off patient accounts, those are allowable and encouraged for Hospital Discounted Care. Facilities and professionals must not create any payment plans that are longer than 36 months of payments, however facilities and professionals may be flexible in allowing patients to skip months and add those payments to the end of the payment plan, resulting in a longer payment plan but retaining a maximum of 36 payments.

Section 2.02 Payment Plan Structure

Health Care Facilities and Licensed Health Care Professionals should contact patients by the patient's indicated preferred method of contact within 30 days of their determination to pay their bill or set up their payment plan unless the patient has submitted an appeal of their determination. Patients have up to 181 days past their date of service or date of discharge, whichever is later, to make a payment. If a patient wishes to pay off their bill all at once and not set up a payment plan, the highest amount that they would be required to pay is the lower of:

- The Hospital Discounted Care allowed amount, or
- The same amount as if they set up a 36-month payment plan at:
    - 4% of their monthly gross income for a bill from the Health Care Facility containing only facility charges,
    - 6% of their monthly gross income for a bill from the Health Care Facility containing both facility and Licensed Health Care Professional charges, or
    - 2% of their monthly income for a bill from each Licensed Health Care Professional.

In addition, automatic payments for the patients should not be set up more than their applicable 4%/6%/2% limits.

It is possible that the allowable billed amount is less than what a 36-month payment plan would be for a patient. In this case, the payment plan can be adjusted either for less money per month and last the full 36 months or it can be set up utilizing the applicable 4%, 6%, or 2% limit for fewer than 36 months. For example, consider a household with a monthly 4% limit of $100. The maximum amount that the household would owe within a payment plan is $3,600. If the allowable billed amount is $4,000, the payment plan can be set up for the full 4% for 36 months, resulting in a write off of $400 either at the beginning or end of the payment plan. If the allowable billed amount is $1,800, the payment plan can be set up at the full 4% ($100) for 18 months, for $50 for 36 months, or any amount in between. Facilities and professionals should work with households to ensure their monthly payment is being set at an amount they can reliably afford each month.

Once a payment plan has been established, a facility or professional may not require a patient to complete a redetermination related to services the payment plan covers. A patient may request to be redetermined if they have experienced a change in household size or income. If the redetermination results in a higher FPG, the monthly amount may be adjusted but the total amount due cannot be changed. If the redetermination results in a lower FPG, the monthly amount must be reduced to adhere to the applicable 4%/6%/2% limits but the length of the payment plan may not be adjusted.

Section 2.03 Pre-Payment or “Paid in Full” Options

Health Care Facilities and Licensed Health Care Professionals are allowed to offer a discounted bill amount if the patient pays in full upfront, but this lower amount must not exceed the allowable billed amount or the amount the patient would be responsible for in the 36-month payment plan, whichever is lower. For example, if the patient’s application determines that their 4% monthly payment amount would be $100, the Health Care Facility would be allowed to offer them a “paid in full discount price” of no more than $3,600. However, if the allowable billed amount for their services is $3,200, the “paid in full discount price” could be set to no more than $3,200.

Section 2.04 Completion of Payment Plan

A patient’s payment plan is considered complete after they have made 36 months of payments or paid the full amount for which they were billed, whichever occurs sooner. A patient is allowed to pay extra towards their payment plan, in either additional monthly amounts or lump sums, in order to shorten its length.

Once the patient has completed their payment plan, the Health Care Facility or Licensed Health Care Professional must consider their balance paid in full for the associated bills and cease any and all collection efforts on the remaining balance.

Section 2.05 Payment Plan Examples

Payment plans may be created for patients at a maximum of 4% of the gross monthly household income for bills from Health Care Facilities containing only facility charges, a maximum of 6% for bills from Health Care Facilities containing both facility and Licensed Health Care Professional charges, and a maximum of 2% of the gross monthly household income for bills from each Licensed Health Care Professional who bills separately from the facility. These are maximums and facilities and professionals are allowed and encouraged to grant payment plans to patients that are more favorable. The following are examples of

various payment plans that can be set for uninsured patients that would fall under the guidelines of Hospital Discounted Care.

Situation: A household is seen at a facility for injuries stemming from a car accident. The household consists of four members, two parents and their minor children. Both parents sustain injuries that require surgery to fix broken bones and internal injuries. The household is screened and completes a discounted care application that results in a household FPG of 205.

Payment Plan Option #1: The family sets up a payment plan that follows the maximum Hospital Discounted Care guidelines: $189 for 36 months for each parent, resulting in a combined payment plan of $378 for 36 months and a total of $13,608.

Payment Plan Option #2: During the conversation of setting up a payment plan, the family indicates that there is no way that they would be able to afford a monthly payment of more than $250. Their payment plan is set at their indicated $250 maximum for 36 months, resulting in a total payment plan of $9,000. The facility then includes the difference between the maximum payment plan and the agreed to payment plan ($4,608) in their annual write off data that is submitted to HCPF.

Payment Plan Option #3: The facility has existing policies that state that the total of all payment plans for a household are capped at 6% of the household's gross monthly income. Using that policy, the facility sets the family's payment plan at $284 for 36 months, for a total payment plan of $10,224. The facility can include the difference between the maximum payment plan and agreed to payment plan ($3,384) in their annual write off data that is submitted to HCPF.

Section 2.06 Missed or Partial Payments

It is possible that due to various circumstances, a household may miss or only partially pay one or more of their monthly payments. Partial payments are not necessarily missed payments. The burden is on the hospital to prove that any partial payments made were not made as a result of a reduction in patient income, rendering the original arrangement too costly for the patient, prior to commencing collections activities. Please see additional information about collections in Article III, and collections for patients with established payment plans in Section 3.03.

As stated in Section 2.01 and elsewhere in this manual, recall that the MAXIMUM set monthly payment amount is 4% of household income on bills from a Health Care Facility containing only facility charges, 6% on bills from a Health Care Facility containing facility and Licensed Health Care Professional charges, and 2% on bills from each Licensed Health Care Professional that bills separately from the facility. Facilities and professionals are encouraged to set up payment plans for less than the maximum amount if the patient indicates they will have a difficult time making payments at the full allowed monthly amount.

Non-profit hospitals, health systems, and provider practices should be cognizant of the requirements related to extraordinary collections efforts, as they relate to non-profit status, required under the Internal Revenue Code. See, e.g., https://www.irs.gov/charities-non-profits/billing-and-collections-section-501r6.

Article III. COLLECTION ACTION

Section 3.01 Collections Process under Hospital Discounted Care

Before assigning or selling patient debt to a collection agency or debt buyer, or before pursuing any permissible extraordinary collection action:

- A Health Care Facility must screen any uninsured patient and any insured patient who requests financial assistance for eligibility for public health coverage and discounted care as defined in Section II: Eligibility and Screening, Article II Screening Process;
- A Health Care Facility and a Licensed Health Care Professional must:
    - Discount the charges for any patient who has been determined eligible for Hospital Discounted Care;
    - Provide in the patient's primary language a plain language explanation of the services and charges being billed and notify the patient of potential collection actions; and
    - Bill any third-party payer that is responsible for providing health care coverage to the patient, regardless of whether the health insurance is in- or out-of-network.

The explanation of the services and billed amounts and the notification of potential collections actions must be sent to the patient or guardian in writing at least 30 days prior to collections actions being started. Patient accounts cannot be sent to collections while they are actively completing the screening/and or application process.

For example, if a patient begins the screening and/or application process on day 180, they will have the full 45 days to submit all the required documentation to complete the application. If the Health Care Facility does not have all the necessary documentation to complete the application on the 46th day past the date the application was started, the collection process may be started.

Beginning September 1, 2022, no Health Care Facility or Licensed Health Care Professional or their billing offices collecting on a debt for hospital services shall engage in any permissible extraordinary collection actions until 182 days after the date of service or date of discharge, whichever is later (C.R.S. 6-20-203[2]).

Section 3.02 Collections Amounts Allowable

Billed amounts pursued by a Health Care Facility and a Licensed Health Care Professional through any collections process may not exceed the applicable discounted care rate established by HCPF minus any payments received from the patient or a third-party payer. If a patient's payment plan resulted in a lower amount owed than the Hospital Discounted Care rate, that amount can be included in the total sent to collections. For example, if the Hospital Discounted Care set rate is $4,500 but the patient's maximum payment plan is $3,600 ($100 per month for 36 months), the facility or professional would be able to send the patient to collections for $4,500 minus any payments received from the patient if the patient were to either not set up a payment plan or stop making payments. See Section 3.03 below for information on the collections timeline for patients who have established payment plans. Health Care Facilities and Licensed Health Care Professionals are not allowed to send qualified patients to collections seeking the full amount of their care.

Section 3.03 Collections for Patients with Established Payment Plans

Collections actions are not allowed to be started for any patient with an established payment plan until after the third consecutive month of missed payments, or 182 days from the date of discharge, whichever is later. After the second missed payment but not prior to 152 days after the date of discharge, the Health Care Facility must send written notification to the patient by the patient's indicated preferred method of contact indicating that potential collections actions may be started if the third payment is missed. If the patient has indicated that their preferred method of contact is by phone, the facility must also send either a follow up letter or email to the patient so that the facility has written documentation that they contacted the patient. The notification must include an opportunity for the patient to report a change in their household size or income that would lower their monthly payment limits. If a change has occurred, the Health Care Facility must offer to complete a new application with the patient and adjust their remaining payments accordingly. If the missed payments are on a Licensed Health Care Professional bill, the Licensed Health Care Professional must inform the Health Care Facility of any patient report of changed household size or income so the Health Care Facility may begin the redetermination process.

For example, if the patient's original application calculated 4% of the patient's monthly income to be $100 but after having their income recalculated it is determined that 4% of their gross monthly income is now $80, their payment plan must be amended to $80 for the remaining term of their 36-month plan. Health Care Facilities and Licensed Health Care Professionals are not permitted to adjust the length of the payment plan to account for lower monthly payments.

Article IV. RATES

Section 4.01 Rate Setting

Rates for Hospital Discounted Care are set annually by HCPF. Rates are determined by comparing the Medicare and Medicaid Base Rates and selecting the higher of the two. New rates will be published annually by July 1 using the most recent Medicare information as of April 1 each year. Rate updates may be completed during the year to account for new procedure codes that go into effect or due to significant rate changes. Additional rate updates outside of the annual update will be communicated via newsletter. Facilities, providers, and stakeholders can sign up to receive Hospital Discounted Care and other newsletters of interest on HCPF's website. Rates can be found on the Hospital Discounted Care Rates web page.

Hospital Discounted Care directs HCPF to set outpatient, inpatient, and professional base rates for all CPT codes or facilities based on the greater of either Medicaid rates or Medicare rates. Any CPT code that is assigned a $0 rate is contained within either or both of the Medicaid or Medicare rates but has neither a Medicaid or Medicare set rate. Facilities and professionals may not use their "normal" rate in lieu of a $0 Hospital Discounted Care set rate.

If a CPT code is not contained within the rates set by HCPF, facilities and professionals may use their own rate when billing. Facilities and professionals are encouraged to apply any

financial assistance they provide outside of Hospital Discounted Care to these rates if the patient qualifies for the facility or professional's internal program.

Section 4.02 Inpatient Service Rates

Inpatient Service Rates are used when a patient has health care provided in a Health Care Facility and is discharged at least 24 hours after admission. Inpatient Service Rates are determined by comparing the Medicare and Medicaid rates for each facility and selecting the greater of the two.

Inpatient Service Rates are subject to eligibility and billing maximums. Inpatient Service Rates files for the current and past fiscal years are available on HCPF's website and include the following:

- Medicare Provider CCN - The CMS Certification number, or "CCN", is a unique hospital facility identifier assigned by the Centers for Medicare & Medicaid Services.
- Hospital Name - The "Hospital Name" is the name of the hospital.
- Rate - The "Rate" is the maximum amount a patient can be charged for inpatient services. This rate is separate from the maximum total amount a patient is responsible for under Hospital Discounted Care.

The Inpatient Service Rate for each Health Care Facility is contained in one file with the rates for all other Health Care Facilities subject to Hospital Discounted Care. Health Care Facilities should use the rate posted under their name/Medicare Provider CCN.

Section 4.03 Outpatient Service Rates

Outpatient Service Rates are used when a patient has health care provided in a Health Care Facility and is discharged in less than 24 hours. Outpatient Service Rates are determined by comparing the Medicare rate and Medicaid base rate and selecting the greater of the two.

Outpatient Service Rates are subject to eligibility and billing maximums. Outpatient Service Rates files available on HCPF's website include the following:

- Procedure Code - A collection of codes that represent procedures and services which may be provided to Medicaid and Medicaid beneficiaries.
- Code Description - The "Code Description" is a shortened explanation of the procedures or services the procedure code is associated with.
- Rate - The "Rate" is the maximum amount a patient can be charged for the associated procedure or service.

The Outpatient Service Rates are posted in multiple files and grouped alphabetically. Health Care Facilities should use the rates posted under their name/Medicare Provider CCN, as rates vary from facility to facility.

Section 4.04 Professional Service Rates

Professional Service Rates are used when a patient receives services from a certified health care professional during a hospital visit. Professional Service Rates do not vary by location and are the same statewide. Professional Service Rates are determined by comparing the Medicare rate and the Medicaid base rate and selecting the greater of the two.

Professional Service Rates are subject to eligibility and billing maximums. Professional Service Rates files available on HCPF's website include the following:

- Procedure Code - A collection of codes that represent procedures and services which may be provided to Medicare and Medicaid members.
- Code Description - The "Code Description" is a shortened explanation of the procedures of services the HCPCS is associated with.
- Rate - The "Rate" is the maximum amount a patient can be charged for the procedure or service.

All Licensed Health Care Professionals use the same rates, so no names or provider numbers are included in the Professional Service Rates files.