COLORADO
Department of Health Care Policy & Financing

303 E. 17th Ave. Suite 1100
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# Hospital Discounted Care Operations Manual

*Fiscal Year 2025-26*

## Section VII: Data Reporting

# Article I. REPORTING REQUIREMENTS

## Section 1.01 Annual Reporting

Annually by September 1, Health Care Facilities and, beginning September 1, 2025, Licensed Health Care Professionals not employed by the facility, are required to report their Hospital Discounted Care data covering the previous State Fiscal Year (SFY). The SFY runs from July 1 to June 30. Data is reported directly to the Department of Health Care Policy and Financing (HCPF) using the templates created by HCPF. The HCPF created templates are required to be used so that data from all facilities and professionals can be combined for HCPF's required reporting. The data is required to contain information on each included patient that allows for it to be disaggregated by race, ethnicity, age, and primary language spoken.

If a Health Care Facility or Licensed Health Care Professional is not capable of reporting the required data either in part or in whole, the Health Care Facility or Licensed Health Care Professional shall submit a second explanatory report to HCPF with their annual data. The second report must list the steps being taken to improve data collection and the date by which the facility or professional will be able to report the required data.

## Section 1.02 Health Care Facility Reporting

Health Care Facilities must report on the number of screenings completed, the number of Decline Screening forms signed, and the number of applications processed for all uninsured patients, as well as the number of screenings completed and number of applications processed for all insured patients who requested to be screened for financial assistance.

On the billing side, Health Care Facilities will be expected to report the number of payment plans created for patients determined eligible for Hospital Discounted Care, the number of payment plans completed for eligible patients, and the number of accounts sent to collections for eligible patients during the SFY. Payment plans should be reported in each SFY they are active.

Health Care Facilities should include services provided by their directly employed professionals within the facility data report. If a directly employed professional provides services to a patient at a facility not associated with the facility or system they are employed by, their portion of the services should still be included in the report of their employer facility, as the facility is the responsible billing party for the employed professional's services. The facility portion of the patient's visit should be reported by the facility the visit occurred within. For example, a professional employed by Facility A travels to rural Facility B to provide specialty services to Facility B's patients. The patient will receive bills from both facilities - Facility A bills for the professional services, and Facility B bills for the facility visit. Both facilities should include the portion they billed for in their respective data reports.

Health Care Facilities must report the following information for qualified patients:

- Patient demographic information that includes race, ethnicity, age, primary language spoken, and insurance status for all uninsured patients and any insured patients who requested financial assistance, in addition to the following information
    - Eligibility screenings completed
        - Total eligibility screenings

        - Number of Unique patients receiving an eligibility screening
    - Decline Screening forms completed
        - Total decline screening forms completed
        - Number of Unique patients declining an eligibility screening
    - Number of Unique uninsured patients who were not screened and did not formally decline screening
    - Reason for eligibility denial
    - Discounted care applications completed
        - Total discounted care applications completed
        - Number of Unique patients completing a discounted care application
    - Discounted care received and the program (Hospital Discounted Care and/or internal charity care)
    - Discounted care eligibility denied
    - Reason for discounted care eligibility denial
    - Number of visits for patients under discounted care
    - Number of admissions for patients under discounted care
    - Number of inpatient days for patients under discounted care
    - Received a payment plan
    - Total number of payment plans created
    - Paid the payment plan in full prior to the cumulative thirty-six months or originally scheduled number of payments
    - Payment plan paid in full due to cumulative thirty-six months or originally scheduled number of payments reached
    - Sent to collections and for what physician/service
    - Number of total accounts sent to collections
    - Minimum, Maximum, and Median of the account balances sent to collections
- Charges, Billed Amounts, and Write off Charges
    - Total Health Care Facility Charges
    - Allowable Billed Amounts
    - Third Party Payments
    - Total Payment Amount due from Patients
    - Write off Charges (Difference between Total Charges, Third Party Payments, and Established Payment Plans or amount due from patient)
- Number of Physicians or Physician Groups that bill separately from the Health Care Facility

## Section 1.03 Licensed Health Care Professional Reporting

Licensed Health Care Professionals are not required to report any screening or application information, as those processes are fully overseen by the Health Care Facilities. Professionals will be expected to report the number of payment plans created for patients determined eligible for Hospital Discounted Care, the number of payment plans completed for eligible patients, and the number of accounts sent to collections for eligible patients during the SFY. Payment plans should be reported in each SFY they are active.

Licensed Health Care Professionals must report the following information for approved patients:

- Patient demographic information that includes race, ethnicity, age, primary language spoken, and insurance status for all patients identified to the professional, either by

the Health Care Facility or by the patients themselves, as being eligible for Hospital Discounted Care, in addition to the following information
    - Number of visits for patients under discounted care
    - Number of admissions for patients under discounted care
    - Received a payment plan
    - Total number of payment plans created
    - Paid the payment plan in full prior to the cumulative thirty-six months or originally scheduled number of payments
    - Payment plan paid in full due to cumulative thirty-six months or originally scheduled number of payments reached
    - Sent to collections and for what physician/service
    - Number of total accounts sent to collections
    - Minimum, Maximum, and Median of the account balances sent to collections
- Charges, Billed Amounts, and Write off Charges
    - Total Professional Charges
    - Allowable Billed Amounts
    - Third Party Payments
    - Total Payment Amount due from Patients
    - Write off Charges (Difference between Total Charges, Third Party Payments, and Established Payment Plans or amount due from patient)

## Section 1.04 Reporting Help

Health Care Facilities or Licensed Health Care Professionals who have questions related to their reporting requirements can contact the Hospital Discounted Care Data inbox, hcpf_HospDiscountCareData@state.co.us. HCPF also holds monthly office hours, the information for which can be found on the Hospital Discounted Care website. The website also includes the most recently published data reporting templates, recorded training sessions, and information on upcoming training among other resources.