COLORADO INDIGENT CARE PROGRAM

FISCAL YEAR 2008

MANUAL

SECTION I

ELIGIBILITY

EFFECTIVE: JULY 1, 2007

THE FOLLOWING MAJOR CHANGES HAVE BEEN MADE TO THE FY 2008 ELIGIBILITY SECTION

Section 7.02 Employment Income
Provides two methods on how to calculate employment income

Section 7.04 (b) Exempt Unearned Income
Provides a definition of work-study income

Section 7.05 Self Employment
Clarified the documentation for self-employment

Section 7.07 In-Kind Earned Income
Provides an updated board value table utilizing the most current Food Stamp allotment figures

Section 9.03 Client Copayments-General Policies
Clarifies observation stay and the copayment resulting from this service

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ARTICLE I. PROGRAM OVERVIEW

The Colorado Indigent Care Program (CICP) is a program that distributes federal and state funds to partially compensate qualified health care providers for uncompensated costs associated with services rendered to the indigent population. Qualified health care providers who receive this funding render discounted health care services to Colorado residents, migrant workers and legal immigrants with limited financial resources who are uninsured or underinsured and not eligible for benefits under Medicaid or the Children's Basic Health Plan.

The Colorado Department of Health Care Policy and Financing (Department) administers the CICP by distributing funding to qualified health care providers who serve eligible persons who are indigent. The CICP issues procedures to ensure the funding is used to serve the indigent population in a uniform method. Any significant departure from these procedures will result in termination of the contract with, and the funding to, a health care provider. The legislative authority for this program was enacted in 1983 under 25.5-3-101, et seq., C.R.S., the "Reform Act for the Provision of Health Care for the Medically Indigent."

Section 1.01 Provisions Applicable to Providers (8.903)

Providers eligible for participation in the CICP must meet the following minimum criteria:

- Licensed or certified as a general hospital, community health clinic, or maternity hospital (birth center) by the Department of Public Health and Environment.

- Assure that emergency care is available to all CICP clients throughout the contract year.

- If the provider is a hospital, the hospital must have at least two obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services as Medicaid clients. In the case where a hospital is located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. This obstetrics requirement does not apply to a hospital in which the patients are predominantly under 18 years of age; or which does not offer non-emergency obstetric services as of December 21, 1987.

Section 1.02 Services Provided Under the CICP (8.902)

Health care services provided to CICP clients must be medically necessary, as determined by the CICP provider. Medical necessity is defined as " . . if it is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and if there is no other equally effective although more conservative or less costly course of treatment available or suitable . . ."

All health care services normally provided at the hospital and/or clinic are regularly available at a discount to CICP clients unless the provider sets a standardized policy that limits available services. Providers must offer emergency services at a discount. The CICP Administration has granted waivers to limit medical services to a specific area or county; however, the waivers do

not exclude the provider from supplying required emergency care at a discount to any CICP client, even if that client resides outside the provider's service area.

If a CICP provider agrees to accept a client transfer from another CICP provider, the client must be provided discounted services from both providers. It is the receiving provider's decision to charge an additional copayment for the service provided. It would be appropriate to charge an inpatient copayment if the client was being admitted to a hospital and the client had only paid an outpatient copayment at the primary provider.

Statute requires that CICP providers prioritize care in the following order:

1. Emergency care: Treatment for conditions of an acute, severe nature which are life, limb, or disability threats requiring immediate attention, where any delay in treatment would, in the judgment of the responsible physician, threaten life or loss of function of a patient or viable fetus, Section 25.5-3-101, C.R.S.;

2. Urgent care: Treatment needed because of an injury or serious illness that requires immediate treatment because the client's life or health may be in danger.

3. Any other additional medical care that may include:

    a. Pharmaceutical services: Some CICP providers provide pharmaceutical services. Providers that offer this service will only fill prescriptions under the CICP discount that are written by doctors on their staff (or a doctor that has contracted at that facility). CICP providers cannot provide pharmaceutical services under the CICP discount unless there is a written mutual agreement between the doctor and the CICP provider.

    b. Inpatient psychiatric care and inpatient drug and alcohol services for up to 30 days per client throughout each state fiscal year (July 1 through June 30).

    c. A provider may subcontract with a third party provider to furnish additional services not available at the CICP provider's facility; i.e., ambulance, specialist's services or pharmaceuticals. The contract must stipulate that the CICP Administration is not a party to the contract and not involved in the negotiations. The third party provider will submit charges, other payments, patient liability and other data as required under the contract directly to the CICP provider. In addition, the third party provider will be reimbursed by the CICP provider and not directly by the Department.

    d. Discounted Prenatal Program: The CICP Prenatal Pricing Program has been discontinued; however, providers are encouraged to utilize provider flexibility and create such a program at their facility, establishing a copayment they feel is adequate to encourage clients to obtain prenatal services. Remember: A provider may charge an additional inpatient copayment for the delivery service, but it is inappropriate to charge an additional copayment for the baby upon delivery. A CICP client must always be charged the appropriate CICP copayment, never a global preset delivery charge. For example, a CICP client cannot be required to pay an additional amount for delivery over and above the copayment amount.

Section 1.03 Excluded Services (8.902 E)

The following services are not reimbursable through the CICP:

1. Elective surgeries that are not medically necessary
2. Nursing home care
3. Chiropractic services
4. Sex change surgical procedures
5. Cosmetic surgery
6. Experimental and non-FDA approved treatments
7. Non-emergent dental services
8. Court-ordered procedures, such as drug testing
9. Abortions, except as specified in Sec. 25-15-104.5, C.R.S.
10. Mental health services as a primary diagnosis in an outpatient or clinic setting. The CICP can reimburse for the services if they are a secondary diagnosis
11. Prescription drugs included in the definition of Medicare Part-D are excluded from CICP eligible clients who are also eligible for Medicare

Section 1.04 Health Coverage Plans (8.900)

CICP IS NOT INSURANCE.

The Colorado Department of Regulatory Agencies, Division of Insurance defines a health coverage plan as a policy, contract, certificate, or agreement of coverage offered to individuals. An insurance contract shall include a list of procedures and benefits covered under the policy. An insured individual shall be entitled to receive a contract and/or evidence of coverage as approved by the Insurance Commissioner as defined in 10-16-102, C.R.S.

The CICP does not offer a specified discounted medical benefit package or an entitlement to medical benefits or funding to individuals or medical providers. Medically indigent persons receiving discounted health care services from qualified health care providers are subject to the limitations and requirements. The CICP makes "it possible to use state funds to partially reimburse providers for services given to the state's non-Medicaid medically indigent residents. Therefore, medically indigent persons accepting medical services from this program shall be subject to the limitations and requirements imposed in this article," Section 25.5-3-101 C.R.S. Therefore, the CICP is not a health coverage plan as defined in Section 10-16-102 (22.5) C.R.S.

Section 1.05 HIPAA (Health Insurance Portability and Accountability Act)

The Department has determined that the CICP is NOT a "covered entity" under the Health Insurance Portability and Accountability Act of 1996 privacy regulations (45 C.F.R. Parts 160 and 164). Because the CICP is not a part of Medicaid, and its principal activity is the making of grants to providers who serve eligible persons who are medically indigent, CICP is not considered a covered entity under HIPAA. The state personnel administering the CICP will provide oversight in the form of procedures and conditions, to ensure funds provided are being used to serve the target population, but they will not be significantly involved in any health care decisions or disputes involving a health care provider or client.

ARTICLE II. CLIENT ELIGIBILITY FOR CICP (8.904)

Section 2.01 Overview of Requirements

The **"CICP Eligibility Section"** contains the program guidelines for determining eligibility. The CICP administration refers to eligibility determination as "the rating process." The CICP administration intends that the rating process be uniform across the state. The rating process takes a "snapshot" of an applicant's financial resources as of the date the rating takes place and a signed application is obtained. Ratings usually occur on the initial date of service. **Ratings are retroactive for services received up to 90 days prior to application.** Therefore, when an applicant who has received services applies for the CICP, the applicant is applying for a discount on already incurred medical charges. Providers may extend the deadline for special circumstances under a policy determined and set by the provider.

Before individuals are found eligible for the CICP, they are referred to as "applicants." After individuals are determined eligible for the CICP, they are referred to as a "clients."

Section 2.02 Instructions for Completing the Application

The Colorado Indigent Care Program Client Application (Application) appears in the Appendix section. When completing the Application, the provider must obtain as much documentation as possible to support the applicant's financial status. Documentation assures that State funds are used appropriately. Except in the event of an emergency, an application can be denied for non-compliance if the client refuses to provide required information or documentation.

The provider should schedule an appointment with the applicant to complete the application within 45 days after the date of service and must make a reasonable attempt to complete the application within 90 days after the date of service. It is in the provider's best interests to ask first-time clients whether or not they have received a CICP rating.

Clients are responsible for notifying the provider's billing office if they have received a CICP rating from another CICP facility. Clients must report CICP eligibility rating to the provider within 90 days of service. If a client fails to report his or her CICP eligibility rating within 90 days, the provider is not obligated to provide a discount.

Section 2.03 Emergency Application (8.904 F.2)

Sometimes it may not be practical to rate an applicant using the regular CICP Application process. For example, an individual seen in an emergency room because of an injury may be unable to provide all of the information or documentation required by the usual application process. For emergency situations, complete the following steps.

1. Use the regular CICP Application, ***but check "EMERGENCY"*** at the top (right corner) of the Application.

2. Ask the applicant to respond verbally to all questions and to sign the Application.

3. Assign a CICP rating based on the verbal information provided.

By following the above steps, you have created an "Emergency CICP Application." An Emergency Application is good for only one date of service in an emergency room. If the client receives any care other than the emergency room visit, you must require the client to submit documentation to support all figures on the Emergency Application OR complete a new CICP Application. If the documentation submitted by the client does not support the verbal information, you must complete a new CICP Application.

An individual can only complete an Emergency Application once a year. Any requests for medical care in the emergency room after the initial date of service must include a completed application accompanied by the requested documentation. Any applicant who meets the definition of homeless (Z rating) is not restricted to completing an emergency application only once a year.

All CICP clients must have an initial rating which is usually valid for one year. However, initial ratings may change for various reasons. The most common method of changing a clients' rating is "client re-rating." See Section 8.02 Client Re-rate (8.906 B), for more complete information.

Section 2.04 Other Provider's Rating

Providers are not required to accept each other's rates if a provider believes the rate was determined inaccurately or that the person was rated incorrectly. If a discrepancy exists, providers are asked to contact each other and arrive upon the correct rating.

Section 2.05 Provider Flexibility

The CICP Administration does not become personally involved with client issues. Each provider is encouraged to establish policies and procedures specific to their facility which do not directly contradict this manual. The CICP Administration is available for informational queries of a general nature. Providers are responsible for determining eligibility. Not all circumstances in determining client eligibility are covered in this manual and the manual is not meant to be all-inclusive.

Section 2.06 Liquid Asset Spend Down

Liquid Asset Spend Down is a provision which enables clients to qualify for the CICP discount even if their current liquid assets exceed the eligibility standards. At their discretion, providers may implement a standardized policy to allow clients who are not currently eligible to "spend down" liquid resources (i.e. bank accounts, stocks) so the client can become eligible for a CICP discount. The amount that liquid assets exceed the eligibility standard (250% of the Federal Poverty Level) can be applied to the current medical bill (paid to the provider). The remainder of the medical bill is then discounted under the CICP. The client is still responsible for the CICP copayment.

Example: A client has employment income of $16,000 per year and has a bank account of $12,500. With a family size of 1, the Family Size Deduction is $2,500, so Equity Resources is $10,000 ($12,500 – 2,500 = $10,000). Total family financial status is $26,000 ($16,000 + $10,000 = $26,000), with no allowable deductions. This person is currently ineligible for a CICP discount, but is unable to pay a current medical bill of $25,000. Using the Liquid Asset Spend Down provision, the client is eligible for a CICP discount at $24,500 (family size of 1, at 250% of Federal Poverty Level), so liquid assets need to be reduced by $1,500 ($26,000 – $24,500 = $1,500). The $1,500 is applied to the current medical bill of $25,000 and paid to the provider as cash. The remaining medical bill is $23,500 ($25,000 - $1,500 = $23,500). The client is now eligible for the CICP discount, with a total family financial status of $24,500 ($16,000 employment income and $8,500 in equity and resources) and the remaining portion of the medical bill can be discounted. The Client is still responsible for the CICP copayment at the I-rating. When reporting information on the CICP Summary Spreadsheet, the provider may record the total bill of $25,000 and the client spend down of $1,500 as a third party payment.

ARTICLE III. MEDICAID (8.904 E.5)

Medicaid is a State and Federally funded program that pays for medical services for low-income families and individuals. Medicaid is a program for the categorically needy, meaning that an individual or family must fall below a certain income/resource limit and qualify for one of the following categories:

Section 3.01 Categorically Needy Families and Children

1931 MEDICAID (AFDC)	AFDC Program is no longer in existence, however, children and families can still qualify for Medicaid-only benefits under certain AFDC guidelines that were in effect on July 16, 1996.
Baby Care Kids Care	This applies to pregnant women and to children up to age 6 in families with incomes below 133% of the Federal Poverty Level and for children up to age 19 at 100% of the Federal Poverty Level.
Foster Care Children	This category covers persons less than 21 years of age for whom a county is assuming full or partial financial responsibility and who are in foster care, in homes or private institutions or in subsidized adoptive homes prior to the final decree of adoption.

- There are a number of application sites at which families may apply for Medicaid-only benefits, or the family may apply at the local County Department of Social Services.

- Pregnant women may apply for Medicaid benefits at a number of presumptive eligibility sites or at the local County Department of Social Services. Presumptive eligibility was reinstated effective July 1, 2005. The application completed by the pregnant woman can be used to apply for Medicaid-only benefits for members of the household. However, presumptive eligibility can be given only to pregnant women, and the application for presumptive eligibility benefits must be made at the presumptive eligibility site.

Questions concerning Baby Care Kids Care should be routed to
Family Health Hotline – 303-692-2229
(Denver Metro)
1-800-688-7777 (toll free)
outside Metro Denver area
OR
The County Department of Social Services
for presumptive eligibility sites

Section 3.02 Elderly & Persons with Disabilities

Old Age Pension (OAP) - Medicaid	Most recipients of Colorado Old Age Pension who are between 60-64 years of age and disabled or over 65 years of age (disabled not a factor over age 65) are eligible for Medicaid and are under 79% of the Federal Poverty Level. Clients are not eligible for CICP.
Old Age Pension – State Only (Health and Medical Care Program)	Recipients of Colorado Old Age Pension who are not eligible for the full range of Medicaid benefits. Approximately 5,000 individuals in the State are covered under OAP Health and Medical Care Program (State Only) and are eligible for CICP.
SLMB (Special Low Income Medicare Beneficiaries)	State pays toward the premium of Part B Medicare only and recipients are eligible for CICP.
QMB-ONLY (Qualified Medicare Beneficiaries)	State pays Medicare Part B premiums (and in some cases Part A premiums) and recipients are not entitled to the full range of Medicaid benefits. State is liable for Medicare deductibles and coinsurance charges only for services covered and approved by Medicare. Clients are eligible for CICP.
Medicare-Medicaid-QMB:	Entitled to the full range of Medicaid benefits, including pharmaceuticals. Also entitled for Medicaid reimbursement of Medicare deductibles, coinsurance, and premiums. Recipients are not eligible for CICP.
Medicare-Medicaid:	Primarily, this applies to some individuals eligible for Medicaid as the result of a need for long-term care in a nursing facility or its alternative. Medicaid is not liable for Medicare deductibles and coinsurance for these clients unless the service provided is a regular Medicaid benefit. Clients are not eligible for CICP.
HCBS & Nursing Home Patients	Disabled individuals needing long term care whose incomes do not exceed 300% of the Supplemental Security Income (S.S.I.) level. Clients are not eligible for CICP.

Home Care Allowance – Cash Assistance	The program provides a monthly cash payment for the purchase of in-home services to low-income, frail elderly or disabled clients, enabling them to remain in their own homes as long as possible.
Adult Foster Care – Cash Assistance	The program provides a monthly cash payment for the purchase of 24-hour supervised non-medical care in an AFC facility for individuals who cannot live alone but don't need medical supervision.

S.S.I. BENEFITS: Residents who are over 65 years of age, blind or disabled, including children, should apply for Supplemental Security Income at their local Social Security office. As soon as they are awarded SSI, they automatically will be enrolled in Medicaid by the local county Department of Social Services.

S.S.I. also provides coverage for:

Persons from age 0 to 64 who are unable to work due to a disability expected to continue longer than 12 months.

Persons with an illness or disability that prevents gainful employment and is expected to result in their death.

S.S.D.I. BENEFITS: Under Social Security, workers are considered disabled if they have a severe physical or mental condition that prevents them from working. The conditions must be expected to last for at least 12 months or to result in death. SSDI benefits are based on previous 40 quarters of earned income history. Once benefits begin, they continue for as long as the worker is disabled and can't work. The disabled worker and eligible family members receive checks each month. ***(Source: Social Security Administration, SSA Publication No. 05-10080, March 1999)***

QMB-only, Medicare-Medicaid-QMB, and Medicare-Medicaid recipients are subject to Medicaid copays, unless enrolled in a Medicaid HMO. (QMB/SLMB-only are not eligible to enroll in Medicaid HMO plans.)

If the applicant appears to meet the eligibility criteria for any of the above Medicaid eligible categories, a denial letter from the local county Department of Social Services must be received. A letter from the Department of Human Services indicating voluntary withdrawal or denial due to refusal to submit complete documentation is not sufficient proof that the patient has applied for Medicaid and been denied. A patient who applies for Medicaid but is denied eligibility is eligible for CICP coverage upon receipt of the denial letter. The provider must retain a copy of this letter with the patient's application as documentation. *If a CICP applicant does not fit in any of the above Medicaid eligible categories do not ask them to provide you with a Medicaid denial*

letter. CICP clients who have furnished Medicaid denial letters in past years and whose financial condition or family size has not changed do not need to submit another letter.

Section 3.03 Incorrectly Enrolling Clients both on Medicaid and CICP

In a report by the Colorado State Auditor, a significant number of individuals were enrolled in Medicaid on the same date as they received services that were charged to the CICP. Many of the overlaps occurred in cases in which individuals had been eligible for Medicaid for a number of months. This indicates that the providers are not effectively screening individuals for Medicaid prior to designating them as eligible for CICP. This is disturbing for both providers and clients because under Medicaid providers receive higher reimbursement and clients receive more benefits and pay lower copayments.

Providers must screen applicants for Medicaid prior to assigning a CICP rating. The Provider Compliance Audit requires verification that the client was not determined eligible for Medicaid. The provider must have all potentially eligible clients apply for Medicaid unless the client would not be eligible due to categorical restrictions. The reason(s) for not directing a client to apply for Medicaid must be documented.

The Department will continue to examine clients who were enrolled in both Medicaid and CICP during the same period. If this situation continues and is considered significant by the Department, there will be increased documentation requirements for enrolling clients on CICP and sanctions against providers who bill both programs for the same service.

Section 3.04 Checklist to Screen for Eligibility in CHP+ and Medicaid

A checklist to screen for eligibility in CHP+ and Medicaid has been developed and is located on the first page of the CICP Client Application (Section I). Each application should contain some indication that a screen for eligibility in Medicaid and CHP+ was completed prior to completing the CICP Application.

Section 3.05 Completing the Medicaid Ineligibility Codes

For each household member on Section I of the CICP Application, please check the appropriate code that determines why an applicant is not eligible for Medicaid:

- **A** Received Medicaid denial letter, attach letter to application
- **B** Does not meet Medicaid standard of assistance of resource level
- **C** Applicant is not a U.S. citizen, has not been a legal resident for at least 5 years, or does not have refugee status
- **D** Applicant is no longer pregnant and beyond post-partum
- **E** Transitional Medicaid benefits have been discontinued
- **F** Individual no longer receiving SSI or SSDI
- **G** Does not meet Medicaid's definition of disability or incapacity and is under 65 years of age

ARTICLE IV. CHILD HEALTH PLAN *PLUS*

The Children's Basic Health Plan, a.k.a Child Health Plan *Plus*, is a state and federal health insurance program for children ages 0 through 18 and pregnant women with family incomes at or below 200% of the federal poverty level. This federal Title XXI program is called the Children's Basic Health Plan in Colorado, but does business as the Child Health Plan *Plus* (CHP+). State legislation directs that services be delivered through HMOs that are willing to contract with Medicaid. The General Assembly appropriates funds for the Children's Basic Health Plan each year, and enrollment will be limited based on this funding.

Section 4.01 Covered Services

Covered services under CHP+ include:

- Inpatient services
- Outpatient services
- Physician services
- Surgical services
- Clinic services (including health center services) and other ambulatory health care services
- Prescription drugs
- Over-the-counter medications
- Laboratory and radiological services
- Prenatal care and pre-pregnancy family services and supplies
- Inpatient mental health services
- Outpatient mental health services
- Home and community-based health care services
- Dental services
- Outpatient substance abuse treatment services
- Medical transportation
- Treatment for neurobiological-based mental illnesses
- Organ transplant
- Vision services
- Audiological services
- Intractable pain treatment
- Autism coverage
- Skilled nursing facility care

Some services will require a minimal copayment, which is based on the family's size and income level.

Prior authorizations from the plan are required before a member can receive certain services or services outside of the plan's network. The child's PCP is responsible for obtaining all necessary prior authorizations. Services requiring prior authorizations include, but are not limited to:

- All outpatient therapies including physical therapy, speech therapy, and occupational therapy
- Services performed by a provider outside the plan's network
- Elective hospital admissions
- Hospice care
- Inpatient and outpatient surgery
- Durable medical equipment
- Some prescriptions
- A complete list of services requiring prior authorization is available to providers in the CHP+ Provider Manual.

Contracts with managed care plans require that the plans have a process in place to permit special needs children to obtain a standing referral for special care.

The CHP+ HMO contracts read:

> Special Health Care Needs: With respect to Clients enrolled pursuant to this Contract, shall mean ongoing health conditions that:
>
> 1) Have a biological, physiological or cognitive basis;
> 2) Have lasted, or are virtually certain to last, for more than one year, and
> 3) Produce one or more of the following sequela:
>   a) Significant limitation in areas of physical, cognitive or emotional function; dependency on medical or assistive devices to minimize limitation or function of activities;
>   b) Significant limitation in social growth or developmental function; need for psychological, education, medical or related services over and above the usual for a Member's age; or
>   c) Require special ongoing treatments such as medication, diet, interventions, or accommodations at home or school.

Section 4.02 Eligibility Requirements

Eligible children are from families whose gross annual income is at or below 200% of the federal poverty level for their family size. CHP+ allows spend downs for medical bills, insurance premiums, day care, elder care, alimony payments and child support.

Section 4.03 Residential Requirements

A resident is anyone who is:

1) U.S. citizen; or
2) Documented legal immigrant who has resided in the U.S. for more than five years; or has refugee or assylee status; or

3) A resident of Colorado.

Section 4.04 Disability Status

No child is denied eligibility based on disability status. Children who receive SSI and are eligible for Medicaid will be denied coverage because they are eligible for Medicaid, not for reasons of disability status.

Section 4.05 Other Health Coverage

A child will be found ineligible for CHP+ if the child:

1) Is covered under a group health plan or under health insurance coverage as defined in section 2791 of the Public Health Service Act; or
2) Is eligible for Medicaid; or
3) Is a member of a family that is eligible for health benefits coverage under a State health benefits plan based on a family members' employment with a public agency in the State; or
4) Has had coverage under an employer plan with at least a 50% employer contribution during the past three months, unless the individual lost health coverage due to a change or loss in employment, or the employer eliminated insurance coverage. There is a three month waiting period for possible eligibility in this case.

Section 4.06 Duration of Eligibility

Once enrolled, a child will be continuously enrolled for one year from the date of the application unless the child moves out of state, turns 19 years old, or becomes enrolled in Medicaid. Renewal letters and packets are mailed to families 60 to 90 days before the day their CHP+ coverage terminates. Families are encouraged to return their completed renewal packet at least 30 days prior to termination to allow continuity of care through their HMO. If the family does not resubmit an application by the ending date of coverage, the child's eligibility may still be renewed, though coverage may be interrupted.

Section 4.07 Family Size

The CHP+ will use the family size and income verification process. To be counted in family size, family members must receive at least 50% of their support from the family unit. Family members cannot include emancipated minors or family members outside of Colorado.

Section 4.08 Income Criteria

Documentation of previous month's employment income and payments received from other sources must be provided. “Cash from other sources” includes gross cash received from:

- Unemployment compensation

- Old Age Pension
- Supplemental Security Income
- Aid to Needy and Disabled Program
- Payments from retirement plans and pensions
- Commissions, bonuses, and tips
- Alimony received by the family making application for the child
- Income from rental properties
- Stipends
- Amounts drawn from trust accounts
- Interest earnings and capital gains

Section 4.09 Enrollment Fee

This annual amount is determined by family income and is capped at $25 for one child and at $35 for two or more children.

Section 4.10 Appeals Process

Applicants shall be notified of any action or denial and informed of their appeal rights, and the appeals procedure.

Section 4.11 How to Contact CHP+

Website www.CHPplus.org

Telephone: 1-800-359-1991.

Section 4.12 Checklist to Screen for Eligibility in CHP+ and Medicaid

A checklist to screen for eligibility in CHP+ and Medicaid has been developed and is located in the Section VI: Client Application, Worksheet 5 of the CICP Application. It is not required that this checklist be used for each application. However, each application should contain some indication that a screen for eligibility in Medicaid and CHP+ was completed prior to completing the CICP Application.

Section 4.13 Completing the CHP+ Ineligibility Codes

For each household member on Section I of the CICP Application, please check the appropriate code that determines why an applicant is not eligible for CHP+:

1 Received CHP+ denial letter, attach letter to application
2 Child is eligible for Medicaid
3 Applicant is not a U.S. citizen and has not been a legal resident for at least 5

years, or does not have refugee status

4 Child has other primary health insurance coverage

5 Child was insured under an employer plan with at least 50% employer coverage in the past 3 months, unless dropped due to change in employment status or employer eliminated coverage

6 A member of the family is eligible for health benefits coverage under State health benefits plan or public agency in the state (i.e., employed by the State Government)

7 Does not meet age requirement, Adult, 19 years of age or older

ARTICLE V. HEALTH INSURANCE INFORMATION (8.904 I)

Applicants with other medical insurance may still qualify for CICP. Therefore, applications should be completed for individuals with other medical insurance. In some cases, other medical insurance may not cover certain medically necessary benefits or applicants may have used all of their benefits. Applicants may not know if their other medical insurance will cover certain charges until after the CICP Application time limit of 90 days has expired**.** Applicants cannot be denied CICP if they have other insurance, but **it is the responsibility of the provider's collection/claims office to bill all other medical insurance companies first before reporting the charges to CICP.**

Section 5.01 Health Insurance

Obtain all information related to the insurance policy and attach a copy of the policy or insurance card to the application. Required information includes the name of the insurance company, the address where the medical claim forms must be submitted, policy number and any other information determined necessary. The clinic or hospital will bill the commercial health insurance policy first for all medical expenses incurred. Unpaid medical expenses will be billed to the CICP minus the health insurance copayment or the CICP copayment, whichever is lower.

Providers can report contractual write-offs required under some commercial health insurance contracts in total charges and are only required to report payments due from the commercial health plan in third party liability. Patient liability is the payment due from third party insurance, including Medicare. This is not payments actually received, but the amount owed by the client's primary insurance. CICP will reimburse for contractual adjustments; therefore, do not include these adjustments as liabilities or as payments due.

Resource types:

- Group Health Insurance
- Military Health Insurance
- Medicare
- Workers' Compensation
- HMO
- Medicaid
- COBRA
- Other commercial health plans

Section 5.02 Medicare Bad Debt

A provider can declare the percentage of Medicare deductibles or coinsurance not reimbursed by the client or a state program as Medicare Bad Debt. If an individual qualifies for a state low-income program (such as CICP), the debt may be deemed uncollectible without applying a reasonable collection effort (such as turning the debt over to a collection agency). Please contact the CICP Administration if you desire copies of these Medicare Regulations.

The maximum a provider can collect from a CICP eligible client is the CICP copayment, even if that client has another primary insurance such as Medicare.

Reimbursement Examples:

Example #1, Client is Eligible for CICP and Pays CICP Copayment

Medicare Coinsurance	$1,000	
Minus CICP Client Copayment	$100	
Equals Amount Charged to CICP	$900	
Minus Amount Reimbursed by CICP	$90	(assumes reimbursed at 10% of Charges)
Equals Amount Added to Bad Debt	$810	
Minus Amount Reimbursed by Medicare	$648	(assumes reimbursed at 80% of Bad Debt)
Equals Total Uncompensated	$162	
Total Amount Received by Provider	$838	($100 + $90 + $648)

Example #2, Client is Eligible for CICP and Fails to Pay CICP Copayment

Medicare Coinsurance	$1,000	
Minus CICP Client Copayment	$100	
Equals Amount Charged to CICP	$900	
Minus Amount Reimbursed by CICP	$90	(assumes reimbursed at 10% of Charges)
Plus CICP Client Copayment Bad Debt	$100	
Equals Amount Added to Bad Debt	$910	
Minus Amount Reimbursed by Medicare	$720	(assumes reimbursed at 80% of Bad Debt)
Equals Total Uncompensated	$190	
Total Amount Received by Provider	$810	($90 + $720)

Section 5.03 Health Insurance Billing Examples:

Example #1: Medicare Third Party Payment with CICP as Secondary Payer

$150.00	Medical bill - Total Charges Billed to Medicare
-$100.00	Minus Payment Due from Medicare
$50.00	Equals Hospital Charges Remaining
$50.00	Hospital Charges Remaining
-$25.00	Minus Client Copayment
$25.00	***Allowable Write-Off Charges Reported to CICP***

Charges Reported to CICP

Total Charges	Patient Liability	3rd Party Liability	Write-Off Charges
$150.00	$25.00	$100.00	$25.00

Example #2: Simple Third Party Payment with CICP as Secondary Payer

$150.00	Medical bill - Total Charges Billed to Client's Commercial Health Plan
-$100.00	Minus Payment Due from Client's Commercial Health Plan
$50.00	Equals Hospital Charges Remaining
$50.00	Hospital Charges Remaining
-$25.00	Minus Client Copayment
$25.00	***Allowable Write-Off Charges Reported to CICP***

Charges Reported to CICP

Total Charges	Patient Liability	3rd Party Liability	Write-Off Charges
$150.00	$25.00	$100.00	$25.00

Section 5.04 Medical Insurance

Charges to the CICP are secondary to all insurance programs.

(a) Group and Individual Health Insurance Applicants may be eligible for CICP coverage. The provider is required to bill the resource listed before submitting the claim to CICP.

(b) Workers' Compensation applicants can participate in the CICP. However, the provider must bill Worker's Compensation before billing the CICP.

(c) Victim's Compensation is the only third party coverage billed after CICP coverage. Victim's Compensation may be used to cover the client's CICP copayment.

(d) HMO (Health Maintenance Organization) clients can participate in CICP; however, out of network services are not covered. Services not available in the commercial HMO insurance policy and deemed medically necessary can be billed to CICP minus the insurance copayment paid by the client.

(e) COBRA (Consolidated Omnibus Budget Reconciliation Act) COBRA benefits are continued health plan benefits provided by the employer. Terminated employees or those who lose coverage because of reduced work hours may purchase the group coverage for themselves and families for a limited period of time. They have 60 days to accept coverage or lose all rights to these benefits. Once COBRA coverage is chosen, they will be required to pay for their coverage.

(f) Medicare eligible clients have CICP coverage for amounts and services NOT covered by Medicare. Medicare has two main types of coverage. Medicare Part A is inpatient hospital coverage available to all people over age 65. Medicare Part B, outpatient services, requires clients to pay a monthly premium. Some Medicare beneficiaries qualify for Medicaid as a Qualified Medicare Beneficiary (QMB). If an applicant has QMB coverage, they can participate in the CICP.

(g) CICP can be used to satisfy the copayment for primary insurance, including Medicare. Clients are responsible for the CICP copayment or the copayment of the primary insurance, whichever is lower.

(h) CICP can be used to satisfy the deductible or coinsurance for primary insurance, including Medicare. Clients are responsible for the CICP copayment or the copayment of the primary insurance, whichever is lower. The deductible or coinsurance should be included in Total Charges billed to the CICP. The only entry into Client Liability is the copayment required.

Section 5.05 Subsequent Insurance Payments

If patients receive coverage under the CICP, and their insurance subsequently pays for services, or if the patient is awarded a settlement, the provider must document any subsequent reimbursement received when submitting their summary data information. See Article VII Previous Charged Claim Adjustments of the Billing Manual on how to document these payments.

Section 5.06 Grants

Grants from foundations to CICP clients from non-profit, tax-exempt, or charitable foundations specifically for CICP client copayments are not considered other medical insurance or income. The provider must honor these grants and not count the grant as a resource or income.

ARTICLE VI. CLIENT APPLICATION (8.904)

Section 6.01 Name

This is the person who is responsible for paying incurred charges. Any non-minor household member can be the responsible party. If an applicant is deceased, the executor of the estate or a family member can complete the Application on behalf of the applicant. The family member completing the application will not be responsible for any copayments incurred on behalf of the deceased member.

Section 6.02 Applicant Address

Applicants' address refers to the residence of all family members included in the rating. All members included under this rating must live at this address. This address cannot be a business address or an empty lot. The family address must be the primary place where the family resides. The CICP Administration determines residency using the criteria outlined in Section 1-2-102, C.R.S. See "Colorado Resident," for more information on the family's primary home.

Clients who are both at or below 40% of the Federal Poverty Level and considered homeless will receive a "Z" rating. Homeless Clients are exempt from client copayments, income verification requirement, verification of denied Medicaid benefits and providing proof of residency when completing the CICP Application.

General Definition: A person is considered homeless who lacks a fixed, regular, and adequate night-time residence or has a primary night time residency that is: (A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations, (B) an institution that provides a temporary residence for individuals intended to be institutionalized, or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings. This does not include an individual imprisoned or otherwise detained pursuant to federal or state law.

Section 6.03 Household Member's Name (8.904 G.1)

Record the name of each family member who has received care, will receive care through the CICP, or will be included in the family size calculation for Line 12, Section II of the Application.

Determining family members to include on the application. The following information will help determine if a family member can receive care through the CICP and/or be counted in family size:

> Family members must receive at least 50% of their support from the responsible party. Proof of support includes the family member being listed on the prior year's tax return as a dependent and/or proof of support expenses through cancelled checks or copies of money orders.

The most common family members include:

- Spouses (including common-law marriage; see index for the definition of common-law marriage)
- Children (see Sec. 6.04 Relationship Codes)
- Stepchildren
- Adopted children
- Unborn children
- Grandchildren
- Step-grandchildren
- Parents
- Step-parents
- Parents-in-law
- Grandparents
- Brothers and sisters
- Brothers-in-law and sisters-in-law
- Son-in-law and daughter-in-law
- Adult Child

These family members should only be considered in family size count ***if*** they receive financial support of 50% or more from the family applying for CICP.

Section 6.04 Relationship Codes

Enter the appropriate Relationship Code number:

1 Self **2** Spouse **3** Child **4** Stepchild **5** Other

(a) Married Couples - BOTH spouses must be included on the Application. Married couples will receive the same CICP rating unless one of the spouses is Medicaid eligible or an undocumented immigrant; in which case, both are still included in family size.

A married couple means that the couple is legally married. Proof of marriage is a marriage license or marriage certificate. Married couples may keep their finances separate, including payments for medical care. However, according to the Joint Liability for Family Expenses, 14-6-110, C.R.S., "the expenses of the family and the education of the children are chargeable upon the property of both husband and wife, or either of them and in relation thereto they may be sued jointly or separately." If one spouse does not want to give the necessary financial information, rate the family based on the best information available. However, inform the non-compliant spouse that according to Colorado law spouses are responsible for each other's medical charges.

Married couples wishing to separate or divorce must provide legal documentation of the separation or the dissolution of marriage to be considered separate for CICP eligibility.

(b) Common Law Marriage - If a man and woman meet the requirements for common law marriage, the same rules apply as with married couples (6.04a). All five of the following requirements must be met for a common-law marriage in Colorado:

1. It must be the INTENT of both parties to be husband and wife
2. Both parties must be 18 years of age or older
3. Both parties must be free to marry (single, widowed, or legally divorced)
4. Both parties must live together
5. Both parties, by reputation, must claim to be married

- If one or more of these conditions are not met, a couple living together is not a "family" for CICP ratings. This means both partners must complete separate applications.
- As with married couples, the wife does not have to take the husband's last name for a common-law marriage.
- Providers may request an affidavit of Common Law Marriage signed by both parties.

(c) Same Sex Marriage - Colorado law does not recognize same sex marriages; therefore, partners of same sex marriages must complete separate Applications. This includes common law marriages between persons of the same sex. The only exception to this exclusion is if one member is a bona fide dependent of the other (based on legal documentation provided). In these cases, count both partners in family size**.**

(d) Minors (under the age of 18) - Minors should not be rated separately from their parents or guardians unless they are emancipated. Exception to this requirement is made for the following reasons:

1. A minor who has a child and obtains medical care for the child (the minor parent is legally responsible for the cost of care)
2. Examination and treatment for sexually transmitted diseases
3. Examination and treatment for alcohol and/or drug addiction
4. Obstetrical and gynecological procedures, birth control procedures, supplies, or information. If the parents of a minor child who is pregnant have insurance to cover that child, but the insurance excludes pregnancy of the minor and the parents are claiming financial responsibility for her, that child is not considered emancipated and should be rated based on the parent's income. If the parents do not qualify for the program, then she cannot be covered under CICP
5. Voluntary mental health services, but only if the minor is fifteen years old or older

6. Treatment or testing for HIV

7. Confidential Teen Services Program - Minors in this program are rated without consideration of their parent's income under the conditions described. Therefore, when minors seek services and claim no income other than the parents' income, they will be rated category A. If the minor declares personal income (e.g., part-time job), that income will be used in determining the rating. If the rating is higher than category A, the higher rating will prevail.

(e) Emancipated Minors - "Emancipated juvenile", pursuant to 19-2-511, C.R.S., means "a juvenile over fifteen years of age and under eighteen years of age who has, with the real or apparent assent of the juvenile's parents, demonstrated independence from the juvenile's parents in matters of care, custody, and earnings. The term may include, but shall not be limited to, any such juvenile who has the sole responsibility for the juvenile's own support, who is married, or who is in the military."

(f) Communal Groups - Do not include unrelated members of religious orders and communal living groups on the same application. Each unrelated member must complete a separate application.

(g) Family Members Outside of Colorado - If a family member lives outside of Colorado, including in a foreign country, that individual is not a Colorado resident. However, count the member in family size if the responsible party provides more than 50% of the member's support and claims the member as a dependent for income tax purposes.

(h) Family Members Eligible for SSI, Child Support, and Foster Care - Include family members receiving cash assistance. Family members receiving only cash assistance can receive care under the CICP if they are not Medicaid eligible.

(i) Family Members Eligible for Medicaid - Family members eligible for Medicaid cannot receive care under the CICP, but can be included in the family size calculation**.**

(j) Additional situations involving children:

1. Unborn Children - Include the unborn child/children of a pregnant woman in family size on the family's Application.

   Do not count unborn children when calculating Board Value for in-kind income. Children under 1 year of age should not be included in the family count when using the Board Value Table to establish food expenses.

2. Children of Divorced Couples - Include children of divorced parents on the custodial parent's application. If the parents have joint custody, the parents must decide which parent will include the children for the CICP rating purposes. If parents with joint child custody cannot agree on which parent will include the child on the CICP Application, the income tax records of the parent with the child listed as a dependent should prevail.

3. Children in School - Include children age 18 years or older who are attending high school or college and whose parents support them, on the parents' application. DO NOT count any income the child may earn.

4. Disabled Children - Include a child with disabilities, regardless of age, on the parent's Application if the parents support the child. If the disabled child is Medicaid eligible, the child cannot receive medical care through the CICP, but should be included in family size. Exception: An adult child with a disability and gainfully employed must complete a separate application.

5. Adult Children - Adult children (defined as 18 years or older) living at home can be counted in the family unit only if the entire family is listed on the application, and the adult child receives 50% of their support from the responsible party. If the adult child has an income, the amount must be included in determining the family financial status. Adult children may submit their own application if they desire, but in this case would not be included on the family application for income or household size.

6. Newborns use the mother's Social Security number up to the age of 1 year.

7. Family Members Eligible for Children's Basic Health Plan (CBHP) - Any family member eligible for the Children's Basic Health Plan may only receive care on a temporary basis under the CICP, but is included in the family size calculation for the CICP.

Section 6.05 Date of Birth

You must enter the date of birth for all family members included in family size or receiving medical care through the CICP, except for unborn children.

Section 6.06 Medicaid State ID Number

If any family member listed receives Medicaid, record the state Medicaid ID number on the application.

Section 6.07 Social Security Number

All applicants must have a Social Security Number. You must enter the social security number for all family members receiving discounted medical care through the CICP. The only exception to this is for unborn children. If an applicant does not have a social security number, effective July 1, 1997, a receipt of application for a Social Security number must be received at the time of CICP Application.

Section 6.08 Residency Code

To qualify for the CICP an applicant must be a Colorado resident, a documented legal immigrant, or a migrant worker.

The CICP has established residency codes to use with the Application. The client must record one of the following residency codes for each family member.

1 Colorado Resident & U.S. citizen
2 Colorado Resident & documented legal immigrant (*includes August 1996*)
3 Migrant farm worker & U.S. citizen
4 Migrant farm worker & documented legal immigrant
5 Non-resident, counted in family size only
6 Medicaid eligible, counted in family size only
7 Counted in family size only

If family members are non-residents (residency code - 05) or eligible for Medicaid (residency code - 06), they cannot receive care under the CICP but can be included in family size. Family members who are eligible for CICP, but do not want to covered under CICP may be counted in family size if they receive 50% of their support from the responsible party (residency code – 07).

(a) Determining the CICP Residency Code

To determine which residency code to record on the Application, use the three steps outlined below for each family member applying for the CICP. All applicants must meet steps 1 and 2 to comply with the CICP's residency requirements.

Step 1. Determine if the applicant is a U.S. citizen using the guidelines listed below. If the applicant is a U.S. Citizen, go to step 2. If the person is not a U.S. Citizen or a documented legal immigrant, the person cannot receive discounted care through the CICP, but can be used to determine family size.

Step 2. Determine if the applicant meets ***one*** of the following:

a. The applicant is a Colorado resident according to the CICP residency requirements listed under "Colorado Resident" ***OR***

b. The applicant is a migrant worker according to the criteria outlined under "Migrant Workers"

Step 3. Record the residency code for each family member

(b) U.S. Citizen

A U.S. citizen is a person who meets **one** of the following:

1. Born in the United States, Puerto Rico, Guam, Virgin Islands of the United States, American Samoa, or Swain's Island. A birth certificate will prove that a person was born a U.S. citizen, ***OR***
2. Received citizenship through the naturalization process. A certificate of citizenship will prove that a person is a U.S. citizen.

(c) Documented Immigrants

Documented immigrants are people who reside in the United States and possess **one** of the following Immigration and Naturalization Service (INS) documents in addition to a Social Security Number:

- I-551 resident alien card
- I-688B or I-766 employment authorization card
- I-94 arrival-departure record
- Immigrants granted "voluntary departure" or "indefinite stay of deportation"

(d) Colorado Resident

A Colorado resident is a person who currently lives in Colorado and intends to remain in the state. Determine if the applicant is a Colorado resident pursuant to section 1-2-102, C.R.S., by asking the following questions:

1. Where is the applicant's primary home? A primary home is the place of residence where a person lives and the place where that person, whenever absent, intends to return, regardless of the length of absence. A primary home cannot be a business address or a vacant lot or a post office box.

2. Is the applicant's primary home address the same as the address on the applicant's motor vehicle registration and state income tax return? If yes, the applicant meets the CICP's residency requirements. Individuals who have recently moved to Colorado must apply for a Colorado title and registration for their vehicle within 30 days from establishing Colorado residency.

(e) Migrant Workers

Migrant workers and all dependent family members must meet all of the following criteria to comply with CICP residency requirements:

1. Do not live permanently in Colorado; temporary living in Colorado for employment reasons

2. Be a U.S. citizen or documented immigrant

3. Employed in Colorado. ***Must have letter of employment***

Eligibility is extended to dependent family members of migrant workers when the residency requirements are met for the CICP including: if the family members establish a temporary home in Colorado and meet U.S. citizenship OR meet established immigration documentation requirements. Requirement number three may not be applicable to all family members.

Section 6.09 Applicants Not Eligible for the CICP

(a) Undocumented immigrants

(b) An applicant in custody of a law enforcement agency. An individual is not eligible when they are serving time for a criminal offense or confined involuntarily in a City, County, State or Federal prison, jail, detention facility, or other penal facility. This includes individuals who are being involuntarily held in detention centers awaiting trial, involuntarily residing at a wilderness camp under any type of governmental control, and involuntarily residing in a half-way house under any type of governmental control. Even if the medical condition is considered "pre-existing" prior to incarceration, once the individual is being held involuntarily under any type of governmental control they are not eligible for CICP.

Prior to Incarceration – The applicant is eligible for CICP. If an applicant has been convicted of a crime but has not reported to the penal facility to start their sentence, the applicant remains eligible for CICP.

Parole or Probation After Incarceration – An applicant on parole or probation is eligible for CICP. An applicant who is living in a halfway house is eligible for CICP only if they are on parole. Most residents of a halfway house are still considered inmates and are involuntarily residing under a type of governmental control. If the applicant has not been officially released through a parole board, he/she is still considered an inmate and is therefore NOT eligible for CICP.

(c) College students from outside Colorado or the United States who are in Colorado for the purpose of higher education. These students are not Colorado residents and cannot receive services under the CICP

(d) Visitors from other states or countries temporarily visiting Colorado who have primary residences outside of Colorado

(e) Persons who qualify for Medicaid

(f) The CICP cannot be used as proof of college medical insurance

(g) Persons who qualify for the Children's Basic Health Plan. However, individuals who are waiting to become an enrollee in the Children's Basic Health Plan and/or have incurred charges at a participating CICP Provider in the 90 days prior to the CICP Application date shall not be excluded from consideration for CICP eligibility on a temporary basis subject to the following:

1. The temporary basis does not exceed 3 months

2. The applicant satisfies all of the client eligibility requirements for CICP

3. Once applicants become enrolled in the CHP+, they are no longer eligible for the CICP

4. Applicants who have been disenrolled from, but remain eligible for, the CHP+, are eligible for the CICP on a temporary basis not to exceed 3 months. If CHP+ determination has not been received at the end of the 3-month period, the applicant may be enrolled in the CICP for an additional 3 months.

5. Applicants who have been disenrolled from, and are no longer eligible for the CHP+, are eligible for the CICP and should be enrolled as regular applicants.

ARTICLE VII. FINANCIAL ELIGIBILITY (8.905)

Include with the Client's Application the full names, phone numbers, and addresses of all employers and retirement payments. Income sources include payments from employment, Social Security, pension funds, unemployment compensation, and self-employment. List the income sources for all family members over the age of 18 (income from a minor aged 15-18 is not counted).

Section 7.01 Determining the Applicant's Income (8.905)

The CICP administration has five methods for determining an applicant's income and establishing financial status. The methods are (in order of priority):

Line 1 - Employment Income

Line 2 - Unearned Income

Line 3 - Self-Employment

Line 4 - Monthly Expenses (this method should be used when the applicant is unemployed and not receiving any unearned income, Section 7.06)

Line 5 - In-Kind Earned Income

Calculate all income beginning with Line 1, "Employment Income."

When calculating income, you must obtain as much documentation as possible to substantiate amounts.

Section 7.02 Employment Income (8.905)

Employment income is income earned (including overtime and bonuses) for providing services to another individual or company. Employment income for CICP does not include self-employment income which is addressed separately. Documentation of employment income is a pay stub or a letter on official letterhead from the applicant's employer**.**

There are 3 steps to calculating current employment income.

Step 1. Obtain documentation for current month or previous months' employment income. Obtain at least one month of information, or a pay stub showing a year-to-date income figure. Complete Worksheet - 1 "Employment 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. Write the total amount of gross employment income in the monthly total column on Line 1, Section II of the application.

Year to Date Method:

The Year-to-Date Method of calculating annualized gross income utilizes the applicants cumulative year-to-date gross earnings on the pay stub. When utilizing this method, the applicant will need to provide their **most current year-to-date paystub**. It is not required to request a full month of paystubs when utilizing this method. To determine the annualized income, count the number of pay periods that have occurred since January 1, then divide that number into the gross year-to-date earnings indicated on the pay stub. The result of this computation is then multiplied by the number of pay periods in a year to determine the annualized gross earnings.

Example:

The applicant provides you with a recent pay stub whose year-to-date earnings are $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
OR
Divide $13,756 by 38 weekly pay periods = $362.00
Multiply $362 by 52 weekly pay periods in a year= $18,824

Average Pay Method:

The Average Pay method of calculating income utilizes the average gross earnings based upon the number of pay stubs provided. When utilizing this method the applicant will need to provide at least a full month of paystubs. To determine the average gross earnings, total all the gross earnings of all the pay stubs provided and divide the result by the number of pay stubs. The result will be the average gross earnings per pay period. Next, determine if the applicant is paid weekly, bi-weekly or semi-monthly (usually the 1st & 15th). Convert the average gross earnings to monthly income.

1. To convert weekly income to monthly income, multiply by 4.333
2. To convert bi-weekly income to monthly income, multiply by 2.1666
3. To convert semi-monthly income to monthly income, multiply by 2

Lastly, annualize the average monthly gross earnings

Example:

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

Add: $534.00, $475.00, $398.00, $534.00, $498.00, $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

Monthly Pay Method

The monthly pay method of calculating income utilizes the most recent monthly pay stub. Utilize the monthly income and annualize.

Step 3. Write the annualized total income from Step 2 on Line 1 in the "Annualized Total" column of the Application

Section 7.03 Unearned Income (8.905)

Unearned income is countable gross cash received from sources other than employment. Complete Worksheet 1 – Employment Income and Unearned Income. Write the total amount of the unearned income on line 3 of the Application. This income can be self-declared.

(a) Unemployment Compensation or Workers Compensation

(b) Old Age Pension (OAP) benefits (financial assistance to low income individuals age 60 and over)

(c) Supplemental Security Income (SSI) except for SSI benefits received for minors. Include cash received from SSI benefits for applicants. Applicants who are Medicaid eligible cannot receive care under the CICP without providing a written Medicaid denial.

(d) Aid to the Needy and Disabled (AND) benefits (financial assistance to low-income persons over age 18 who have a disability which is expected to last six months or longer and prevents them from working)

(e) Payments from Retirement Plans and Pensions. Retirement plans and pensions come in many forms. Some examples are: PERA, Tax Sheltered Annuities, Deferred Compensation, Individual Retirement Accounts (IRAs), 401k plans, and Social Security Benefits. Do not include Social Security Benefit payments to children when calculating other income sources on the Application. The provider must receive proof that the Social Security Benefit checks include the child's name. If the checks do not include the child's name, then include these payments in other income sources on the Application.

(f) Commissions, Bonuses, Gifts and Tips. Include amounts from commissions, bonuses, gifts and tips when calculating unearned income on the Application.

(g) Court-Ordered Alimony Received

(h) Trust Accounts are income from other sources.

(i) Income from rental properties, net of expenses earned from rental operations, including boarding and lodging, when calculating other income sources on the Application.

(j) Interest Income includes interest earnings from savings accounts, stocks, bonds, and similar securities when calculating other income sources on the Application

(k) Monetary gains from selling an asset are counted as other income sources on the Application

(l) Insurance policies that are revocable (with cash surrender value)

(m) Monetary settlements received not related to a medical injury accident.

Section 7.04 Exempt Unearned Income (8.905)

The following types of unearned income are ***not included*** in determining total income.

(a) Aid to the Needy and Disabled (AND) payments to Medicaid clients

(b) College grants, scholarships and work-study income. Work-study income is generally awarded based on financial need and is determined by completing a Federal Student Aid Application.

(c) Grants to CICP clients from non-profit, tax-exempt, charitable foundations specifically for CICP client copayments. The provider must honor these grants as CICP client copayments.

(d) Child Support and Foster Care Payments. These payments are for the support of children. Many children receiving these payments are Medicaid eligible. Therefore, require a Medicaid denial before allowing these children to receive care under the CICP.

(e) Food Stamps and Women, Infants, and Children (WIC)

(f) Assistance provided by non-profit organizations, if the assistance is need-based (i.e., the cost of meals at a soup kitchen)

(g) Medical care provided for free or if a third party made the payments

(h) Settlements received as a result of a prior medical injury; not related to the current CICP Application

(i) Reimbursement for work- related personal expenses

(j) College loans

(k) Payments by credit life or credit disability insurance

(l) Proceeds of a loan

(m) Income from a reverse mortgage

(n) Disaster relief assistance

(o) Tax refunds

(p) IRAs, pensions and insurance policies (irrevocable policies) that are not available without penalty

(q) Moving expenses paid by employer for relocation

Section 7.05 Self-Employment (8.905)

Refer to Worksheet 2 to determine the net self-employment income. (It is highly recommended to use Monthly Expense Worksheet #3 in place of determining net self-employment income.) If the family pays themselves just as they would their employees, and can document by pay stubs, use the figure from the pay stub.

(a) To determine the net profit of a self-employed applicant, deduct the cost of doing business from the gross income. To obtain the gross income, request one month of gross bank business deposits. A profit and loss worksheet OR a ledger is acceptable documentation for gross income and business expenses. If the applicant does not have a profit or loss worksheet or a ledger, expenses can be self-declared. The applicant should complete Worksheet 2 and list each business expense. Expenses can include but are not limited to:

- Rent of business premises
- Wholesale cost of merchandise
- Utilities
- Taxes
- Labor
- Upkeep of necessary equipment

(b) Self-employment expenses do not include:

- Depreciation of equipment.
- 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.

(c) Self-employed licensed, certified or approved day care providers may receive the following deductions each month to compensate for wear and tear on the residence:

- $55 for the first child for whom day care is provided.
- $22 for each additional child.

However, if the client can document a cost of doing business, which is greater than the amounts described above, use the expenses identified in Section 7.05 (a).

Section 7.06 Current Monthly Expenses (8.905)

Use the "Current Monthly Expenses" method for calculating income for applicants who are unemployed and/or living on their credit cards. Current Monthly Expenses may be used for an

applicant with fluctuating income. This method is particularly helpful in screening seasonal or migrant workers.

Calculating Monthly Expenses

Obtain at least one month of documentation to verify all monthly expenses. However, if some of the documentation is not available, you can rely on the applicant's verbal responses. Documentation may include actual receipts, credit card statements, credit checks, and records of checking and savings account activity. To calculate monthly expenses, complete the "Monthly Expense Worksheet 3" of this Manual and the following 4 steps:

Step 1. Obtain information and documentation on monthly living expenses to complete the "Monthly Expense Worksheet 3" of this Manual.

Step 2. Determine Total Income by monthly expenses from Worksheet 3 of the manual.

Step 3. Write this amount on Line 5 in the "Monthly Amount" column of the Application.

Step 4. Multiply the amount from Step 3 by 12 to determine the applicant's annualized (12 months for the year) total. Write this amount on the "Annualized Total" column of the Application. The eligibility technician and the client must sign and date this Worksheet.

Section 7.07 In-Kind Earned Income (8.905)

In-Kind earned income is the value of goods and services received as a substitute for monetary payments. These goods and services are usually room (shelter) and board (food). For example, many ministers reside in rent-free houses furnished by their congregations. Live-in companions or domestics usually receive room and board in addition to their basic pay. Apartment complex managers frequently receive a rent-free apartment for managing the complex.

Shelter costs for an ***individual*** must be equal to the going rate in the community. **Determine the current market rental value of the property.** This is the amount the provider would charge when renting the dwelling on the local open market. Included in this amount may be such items as the amount the household pays for mortgage payments, real property taxes or rent, heating fuel, gas, electricity, water, sewage and garbage collection. **Determine the number of individuals in the household, and then divide the market rent by this number. This amount will be written on the Application as the individual's share of rent.**

If ***self-employed applicants*** live in rooms that are part of their place of business, you must include in-kind income on the Application. When determining rent or mortgage amounts under the "In-Kind Income" method, the current market rental value of the property must be determined. This is the amount property owners would charge if they rented the dwelling on the local open market. Included in this amount may be such items as the amount the household pays for mortgage payments, real property taxes or rent, heating fuel, gas, electricity, water, sewage and garbage collection. The total rent would be divided by the number of rooms in the

household used for the business; thereby the end result will be the amount of in-kind income to use on the application for self employment.

The ***Board Value*** table shows the annual value of food. To use the Board Value Table, determine the number of family members and use the annual value under that number for in-kind income. ***Do not include*** unborn children in the Annual Board Value calculation or children less than 1 year of age.

ANNUAL BOARD VALUE TABLE

Family Size	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
	$1,860	$3,408	$4,896	$6,216	$7,380	$8,856	$9,792	$11,184
For families larger than eight, add $1,404 per year or $117 each month per family member								

Section 7.08 Total Income

To calculate total income for Section II of the application, ADD "Gross Employment Income (line 1)" PLUS "Self Employment Income (Line 2)" PLUS "Unearned Income (Line 3)". Take the total from lines 1, 2, and 3, and record the amount in "Total Income (line 4)". If no income is documented, use the Monthly Expense Calculation from worksheet 3, and record the amount in line 5. Record the number from EITHER line 4 or line 5 in "CICP Income Calculation (line 6)."

Section 7.09 Calculating Equity in Resources (8.905)

The "Calculating Equity in Resources" portion of the Application shows the amount of equity in resources available to an applicant.

(a) Calculating Vehicle Equity

For calculating the amount of vehicle equity to record on the Application, complete the following steps:

Step 1. Determine the total value of all vehicles owned by the applicant. Write this amount on Line 7 under the "Actual Value" column. To determine the value of vehicles, request a copy of the client's vehicle registration.

Step 2. Determine the total amount owed on all vehicles owned by the applicant. Write this amount on Line 7 under the "Amount Owed" column of the Application. You should receive confirmation (verbal or written) from the applicant's bank to confirm outstanding vehicle loans.

Step 3. The CICP protects a total of $4,500 ("Minus Protected Portion" column) for all vehicles owned.

Step 4. Subtract the "Amount Owed" and $4,500" **FROM** the "Actual Value" of all vehicles. Write this amount on Line 7 under the "CICP Equity Calculation" column of the Application. If this amount is less than zero (a negative amount), you must record $0 in the "CICP Equity Calculation" column.

Vehicle Equity - Example

An applicant has 2 vehicles. One vehicle is valued at $9,000 but the applicant owes $8,000 on this vehicle; the second vehicle is valued at $2,000 with no money owed. The "Value" is $11,000 ($9,000+$2,000). The "Amount Owed" is $8,000. Therefore, the equity is $3,000 ($11,000-$8,000) before subtracting the Protected Portion. The "Minus Protected Portion" is always $4,500. The "Amount to Use for the CICP" is $0 since $3,000-$4,500 is -$1,500. For the CICP, you cannot record negative numbers.

(b) Real Property

Report net resource value (value minus owed) of resources such as houses or land (other than the primary residence) not occupied as the home. This amount is added to the family's equity in assets.

An applicant must have transferred ownership of personal or real property prior to three years (For transfers made before February 8, 2006) and prior to 5 years (For transfers made on or after February 8, 2006) of the date of their CICP application not to count this property as a resource. This stipulation follows the Medicare regulations.

(c) Liquid Resources

Liquid resources are resources that can be converted to cash immediately. Examples of liquid resources are: checking accounts, saving accounts, trust accounts (if funds are available immediately), the cash value of life insurance, short-term Certificate of Deposits (CD's), and partnership earnings kept in reserve. Retirement accounts and Tax Sheltered Annuities are liquid resources, if the applicant can draw funds out of the account without a penalty.

For applicants with a partnership (i.e. partnership in a farm), request their Federal Income Tax Schedule K-1 and Schedule E. Schedule K-1 summarizes the total amount of cash available to all partners. Schedule E shows all partnership agreements and the amount earned by the partnership. Include that amount of cash available to the applicant in the liquid resource calculation on the Application.

The following example explains how to calculate liquid resources for the CICP. An applicant has $3,000 in savings plus they can withdraw $2,000 from a Tax Sheltered Annuity without penalty. Their total liquid resources are therefore $5,000.

It should be made clear to applicants that liquid resources that can be made available without penalty must be used even if the applicants believe their savings are their "reserves."

(d) Business Equity

If the applicant owns a business, the provider must include any business equity in excess of $50,000 on the Application. The business equity should be calculated when the provider is determining the applicant's net self-employment income. To calculate business equity for the CICP, complete the following steps:

Step 1. Determine the "Actual Value" of all businesses owned by the applicant. Write this amount on Line 10, under the "Value" column of the Application. To determine the value, ask the applicant or contact the financial institute holding the loan on the business.

Step 2. Determine the "Amount Owed" on all businesses. Write this amount on Line 10, under the "Amount Owed" column of the Application. To determine the amount owed, request documents from the applicant's lender.

Step 3. The CICP protects a total of $50,000 ("Minus Protected Portion" column) for all businesses owned.

Step 4. Subtract "Amount Owed" and $50,000 ("Minus Protected Portion") **FROM** the "Value" of all businesses owned. Write this amount on Line 10 under "Amount to Use for the CICP" column of the Application. If this amount is less than $0 (a negative amount), you must record $0 and not the negative amount.

(e) Total Equity in Resources

"Total Equity in Resources" is Lines 7, 8, 9 and 10 of the CICP Client Application or Line 7 of the CICP Worksheet 1 (Calculating the Rate). This cannot be a negative number. If you get a negative number on either form, enter $0 (zero).

Section 7.10 Less Family Size Deductions

The CICP protects $2,500 in resource equity per family member on the Application.
There are two steps to calculating the "Family Size Deduction:"

Step 1. Write the number of family members in the applicants listed on the "Family Member Table," on the Application on Line 12 - "Family Size."

Step 2. Multiply the family size obtained in Step 1 by $2,500. Write this amount on the last blank Line of Line 12.

Section 7.11 Equity in Resources for the CICP

Line 13, "Equity in Resources for the CICP," is Line 11, "Total Equity in Resources," minus Line 12, "Less Family Size Deduction," which equals Line 13, "Equity in Resources for the

CICP." If this amount is less than $0 (a negative amount), you must record $0 and not the negative amount.

Section 7.12 Total Family Financial Status (8.905)

Line 14, "Total Family Financial Status," is, Line 6, "Total Income," PLUS, Line 13, "Equity in Resources for the CICP" from the CICP Client Application. This amount cannot be zero. The amount in Line 10 or Line 14 estimates what the family will have to live on over the next 12 months.

Section 7.13 Allowable Deductions (Expenses, self-declared) (8.905)

The following are allowable deductions (expenses) and may be self-declared. Waivers may be granted from the CICP Administration to those providers who wish to require documentation. For the following expenses, request amounts paid in the past 90 days and annualize.

(a) Daycare and elderly care expenses incurred by the family. This does not include vacation or entertainment expenses for these services.

(b) Child support payments

(c) Alimony paid by the applicant

(d) Health insurance premiums

Section 7.14 Allowable Deductions (Must be documented)

Medical expenses for services received at a hospital, clinic, private physician's office, and pharmacist are allowable deductions and must be documented. In addition, allowable deductions include medical services prescribed by a physician rendered for vision, dental, durable medical equipment (DME), and pharmaceuticals.

- The amount of medical bills if paid or outstanding from any medical provider may be deducted from the income if incurred from the application date back 365 days. Do not annualize these figures, since the amount already is a yearly amount. All deductions must be documented.
- The amount of medical bills if paid or outstanding from a CICP provider **may not** be deducted from the income if incurred within the 90 days prior to the application date. These medical bills will be received at the CICP discount to the client and cannot be included as a deduction on the application. Copays to a CICP provider are not an allowable deduction.

To calculate the deductions for Line 15 of the CICP Client Application, perform the following steps:

Step 1. Request amount paid in the previous month or previous year for medical expenses.

Step 2. Complete Worksheet 4 for the allowable deductions.

Step 3. Record the Grand Total on Line 15 of the CICP Client Application or Line 4 of the CICP Worksheet 1 (Calculating the Rate). Do not annualize one-time or annual payments.

Section 7.15 Net CICP Income and Equity in Resources (8.905)

Line 14 of the CICP Client Application, "Total Family Financial Status" minus Line 15 of the CICP Client Application, "Less Allowable Deductions determines Net CICP Income". This process has already been accomplished on the CICP Worksheet 1 (Calculating the Rate). Line 16, "Net CICP Income and Equity in Resources," is the amount to use for determining if a family qualifies for the CICP.

ARTICLE VIII. CICP RATING (8.906)

The CICP rating determines a family's copayments and client copayment annual cap. CICP ratings are effective for one year from the date of the rating, unless the client's financial situation changes or the rating is a result of a provider management exception.

Any family member eligible for the Children's Basic Health Plan may receive a CICP rating on a temporary basis of three months. This rating is retroactive for services received 90 days prior to the application and valid for three months from the application date.

"CICP Rating Box" is where you record the CICP letter rating or "Denied" for the applicant. You must assign a rating or denial and notify the applicant of his/her status within five working days of the applicant completing the Application.

The denial letter should include a statement informing the applicant that he/she has 15 days to appeal the rating. The denial letter should clearly identify to whom the letter is addressing, with an address and phone number. Family members receiving CICP care under the same Application all have the same CICP rating.

CICP ratings are usually effective for 12 months from the date of the application. Extenuating circumstances sometimes require that the rating be effective for a shorter period of time. When a client is rated for a period lesser than 12 months, it is the responsibility of the primary rating provider to perform the re-rating within the specified time.

Section 8.01 Determining the CICP Rating (8.906 A)

To determine the CICP rating, complete the following steps:

On the CICP Ability to Pay Scale locate the appropriate family size corresponding to the family size recorded on Line 12 of the Application.

Slide across the CICP Ability to Pay Scale until you find the range where the family's "Net CICP Income and Equity in Resources" (Line 16 of the Application) falls. The letter rating at the top of this column is the family's CICP rating.

The letter codes mean the following:

> **N** = 40% of FPL, families rated at this level should be referred to Medicaid before CICP is considered.
>
> **A, B, C** = Families falling within this rating are up to 100% of FPL and should also be referred to Medicaid.
>
> Single adults who fall within the first 4 ratings and are not pregnant may not be eligible for Medicaid.

Women rated at the **D** and **E** level and who are pregnant are possibly eligible for Medicaid or other entitlement programs. Refer those women to Medicaid and require them to have a denial letter prior to participating in the CICP.

F, **G, H, and I** = Families not eligible for Medicaid; their children should be referred to CHP+.

Z = Homeless individual at 40% of FPL. There is no copayment required for this rating.

Record the family's CICP rating in the "CICP Rating" box of the Application. If the family does not qualify for the CICP, write "Denied" in the "CICP Rating" box of the Application.

Give the family a copy of the completed Application.

Example: The family completing the application has 5 family members, as documented on Line 12 of the Application. The family's "Net CICP Income and Equity in Resources" figure is $27,955, as documented on Line 16 of the Application. Turn to the "CICP Ability to Pay Scale" in this Manual. In the "Family Size" column, find 5. Go across the scale until you are in the $27,379 to $31,122 range. The family's income is within this range ($27,955). Record an "E" as the family's CICP rating in the "CICP Rating Box" of the Application.

Section 8.02 Client Re-rate (8.906 B)

Clients are re-rated when their financial situation has changed since the initial rating. Client re-ratings affect only future charges. Therefore, bills incurred after the initial rating but prior to the re-rating are discounted based on the client's initial rating.

When clients request a re-rating and can document that their circumstances have changed since the initial rating, you must re-rate them. Reasons for a re-rating to occur many include one or more of the following:

a. Family income has changed significantly;
b. Number of dependents has changed;
c. An error in the calculation; OR
d. The year rate has expired

ARTICLE IX. CLIENT COPAYMENT (8.907)

Section 9.01 Client Annual Copayment and Cap (8.907 A)

For all client ratings except those with an N-rating, annual copayments for CICP clients cannot exceed 10% of the family's "Total CICP Income and Equity in Resources," recorded on Line 16 of the Application. Annual copayments for clients with N-ratings cannot exceed $120.

The CICP Client Annual Copayment Cap (annual cap) is based on a calendar year (January 1 through December 31), even if a client's rating is for a different year (i.e., April 1 through March 31). Clients are responsible for any charges incurred prior to receiving their CICP rating. Clients are responsible for tracking their copayments and informing the provider in writing (including documentation) when they meet their annual cap. However, if clients overpay their annual cap and inform the provider in writing, the provider's facility must reimburse the client for the amount overpaid.

The client's annual cap can change during the calendar year if the client is rated again. All copayments made toward the old annual cap during the calendar year apply to the new cap. The annual cap amount starts completely over again on January 1st. If a client is admitted to the hospital in December and discharged in January, copayments will be collected in a new calendar year. Therefore, the client's copayment made for the discharge in January applies to the new calendar year's annual cap.

Annual caps apply to charges incurred only after a client is eligible for the CICP, and apply only to services incurred at a CICP provider. For example: A client received services from a provider's facility in March and did not qualify for the CICP. In November, the client receives services from a provider's facility and does qualify for the CICP. Payments made by the client for the services received in March do not apply to the annual cap.

Sometimes clients want to prepay their annual cap prior to receiving services. The CICP Administration does not support this practice because if the client does not incur charges equal to the prepaid copayment cap, the provider's facility will need to refund the overpayment to the client.

Section 9.02 Calculating the CICP Client Copayment Annual Cap (8.907 C)

To calculate the "CICP Client Copayment Annual Cap," multiply Line 16 of the Application by 0.10 (10%). (Do not round Line 16 up to the next highest dollar amount.) Enter this amount on the "Annual Cap" Line in the Client Copayment box.

Example: In February, a family of four applies for the CICP. Their "Net CICP Income and Equity in Resources," Line 16, is $12,000. Their CICP rating is "B." Their CICP annual cap is $1,200 ($12,000 x 0.10). By July, the family has paid $300 in copayments. The mother loses her job in June, so the family is re-rated. Their new income is $10,000. Their new CICP rating is "A," and their new annual cap is $1,000 ($10,000 x 0.10). The family is still responsible for

$700 ($1000 new annual cap minus $300 copayments already paid) in copayments for the calendar year.

Section 9.03 Client Copayments - General Policies (8.907 A)

CICP clients are responsible for paying a portion of their medical bills. The client's portion is called the "client copayment." CICP providers must charge each CICP client a copayment. The CICP Administration recommends that CICP providers require clients to pay their copayment prior to receiving care (except emergent care). For the CICP, there are different copayments for different service charges. The following information explains the different types of medical care charges and the related client copayments:

a) Hospital inpatient facility charges are for all non-physician (facility) services received by a client while receiving care in the hospital setting for a continuous stay longer than 24 hours. The client is responsible for the corresponding Hospital Inpatient Copayment.

b) Hospital outpatient charges are for all non-physician (facility) services received by a client while receiving care in the hospital setting for a continuous stay less than 24 hours (i.e., emergency room care). The client is responsible for the corresponding Hospital Emergency Room Copayment.

c) Physician charges are for services provided to a client by a physician in the hospital setting, including emergency room care. The client is responsible for the corresponding Physician Copayment.

d) Outpatient charges are for all non-physician (facility) and physician services received by a client while receiving care in the outpatient clinic setting, but do not include charges from outpatient services provided in the hospital setting (i.e., emergency room care, ambulatory surgery). Outpatient charges include primary and preventive medical care. The client is responsible for the corresponding Outpatient Clinic Copayment.

e) Specialty Outpatient charges are for all non-physician (facility) and physician services received by a client while receiving care in the specialty outpatient clinic setting, but do not include charges from outpatient services provided in the hospital setting (i.e., emergency room care, ambulatory surgery). Specialty Outpatient charges include distinctive medical care (i.e. oncology, orthopedics, hematology, pulmonary) that is not normally available as primary and preventive medical care. The client is responsible for the corresponding Specialty Outpatient Clinic Copayment. A qualified health care provider must receive written approval from the Department to charge the Specialty Outpatient Clinic Copayment.

f) Laboratory Service charges are for all laboratory tests received by a client not associated with an inpatient facility or hospital outpatient charge during the same period. The client is responsible for the corresponding Laboratory Services Copayment.

g) Prescription charges are for prescription drugs received by a client at a qualified health care provider's pharmacy as an outpatient service. The client is responsible for the corresponding Prescription Copayment. To encourage the availability of discounted prescription drugs, providers are allowed to modify (increase or decrease) the Prescription Copayment with the written approval of the Department.

h) Ambulatory Surgery charges are for all operative procedures received by a client who is admitted to and discharged from the hospital setting on the same day. The client is responsible for the corresponding Inpatient Hospital Copayment for the non-physician (facility) services and the corresponding Physician Copayment for the physician services.

i) The client is responsible for the corresponding Hospital Inpatient Copayment for Magnetic Resonance Imaging (MRI), Computed Tomography (CT) and nuclear medicine services received by the client.

j) Z-Rating. These are homeless clients who are at or below 40% of the Federal Poverty Level (qualify for an N-Rating). Homeless clients are exempt from client copayments. Homeless patients are also exempt from the income verification requirement, verification of denied Medicaid benefits requirement, and providing proof of residency when completing the CICP application.

k) Observation Stay. If a client is in the hospital for more than 24 hours, the Hospital Inpatient copayment is charged. If a client is in the hospital for less than 24 hours, the Hospital Emergency Room copayment is charged, unless one of the following procedures takes places: ambulatory surgery, MRI, CT Scan, or Nuclear Medicine, in which then the Hospital Inpatient copayment is charged.

Section 9.04 Determining a Client's Copayment (8.907 D)

Using the client rating recorded in the ”CICP Rating Box,” look up the corresponding rating on the “CICP Client Copayment Table”. The copay amount is listed by service.

Section 9.05 Responsible Party Signature

The responsible party listed on the first line of the Application must sign the Application within 90 days of the date of service. If an applicant is unable to sign the Application or has died, a spouse, relative, or guardian can sign the Application. An unsigned Application means the Application has not been completed, the applicant cannot receive a discount for services under the Program, and the applicant has no appeal rights. The Application must be completed before the responsible party can sign.

The prospective client has 15 days to provide requested information. The application completion process must be completed within 45 days. If requested documentation is not provided by the applicant, the provider has the right to deny CICP eligibility. The client has a right to obtain a copy of the completed application.

Section 9.06 CICP Policy on Fraudulent Applications

Clients should be notified of the following State Statutes prior to signing the CICP Application:

C.R.S. 25.5-3-111 Penalties – CICP Statutes

Any person who represents that any medical service is reimbursable or subject to payment under this article when he or she knows that it is not and any person who

represents that he or she is eligible for assistance under this article when he or she knows that he or she is not commits a class 2 misdemeanor and shall be punished as provided in section 18-1.3-501, C.R.S.

C.R.S. 18-5-102 - Forgery

(1) A person commits forgery, if, with intent to defraud, such person falsely makes, completes, alters, or utters a written instrument which is or purports to be, or which is calculated to become or to represent if completed:

   (a) A written instrument officially issued or created by a public office, public servant, or government agency.

(2) Forgery is a class 5 felony.

C.R.S. 18-1-105 Felonies classified - presumptive penalties

Class 5 Felonies carry a minimum sentence of one-year imprisonment up to a maximum sentence of three years imprisonment with a mandatory period of parole of two years. In addition, a minimum fine of one thousand dollars up to a maximum fine of one hundred thousand dollars may be imposed.

C.R.S 18-5-114 - Offering a false instrument for recording

(1) A person commits offering a false instrument for recording in the first degree if, knowing that a written instrument relating to or affecting real or personal property or directly affecting contractual relationships contains a material false statement or material false information, and with intent to defraud, he presents or offers it to a public office or a public employee, with the knowledge or belief that it will be registered, filed, or recorded or become a part of the records of that public office or public employee.

(2) Offering a false instrument for recording in the first degree is a class 5 felony.

(3) A person commits offering a false instrument for recording in the second degree if, knowing that a written instrument relating to or affecting real or personal property or directly affecting contractual relationships contains a material false statement or material false information, he presents or offers it to a public office or a public employee, with the knowledge or belief that it will be registered, filed, or recorded or become a part of the records of that public office or public employee.

(4) Offering a false instrument for recording in the second degree is a class 1 misdemeanor.

Reporting fraud is the responsibility of the provider who completed the CICP Application for the implicated client.

If a provider is notified that a client has possibly committed fraud on a CICP application, that provider is responsible for notifying the District Attorney of the client's county of residence, in writing. The provider should not turn over the CICP Application, medical records or billing records without a direct request from the District Attorney. The CICP Application is property of

the State, stored and maintained by the provider. If the District Attorney requests the CICP Application, that application and all supporting documentation must be provided.

If the provider is notified that a client has possibly committed fraud on a CICP application, but that provider did not complete the CICP Application, that provider is responsible for notifying the CICP provider who did complete the application of the report. That notification should be in writing.

The CICP Administration should be copied on all correspondence. The CICP Administration has been directed to assist all inquiries from the District Attorney, but will not submit any formal request for an investigation to the District Attorney. There is no State Agency with the authority to investigate fraud on the CICP application.

Once the provider has notified the District Attorney, the provider is not responsible for any further action unless requested the District Attorney or the CICP Administration.

If the provider receives any reimbursement on a claim previously reimbursed by the CICP due to fraud, or any other reason, the provider must notify the CICP Administration in accordance with the CICP Manual. (See Section II: Data Collection, Article VII. Previously Charged Claim Adjustments.)

ARTICLE X. APPEAL PROCESS (8.908)

Section 10.01 Re-rating

To re-rate a client, you must complete a new CICP Application.

Sometimes even though clients' financial situations may not have changed, they feel their initial ratings do not accurately reflect their current financial situations. The CICP has several methods for changing a CICP client's initial rating. The methods are listed in order below.

a. Provider Management Appeal, Section 10.03
b. Provider Management Exception, Section 10.04

Section 10.02 Instructions for Filing an Appeal (8.908 B)

You must inform the client that they have the right to appeal if they are not satisfied with the rating. All appeals must be handled at the provider level. For example, the client must receive a written denial for a provider management appeal and management exception. A client can request a provider management appeal and/or exception in the same letter. Each of these methods requires the clients to submit a written request and provide documentation supporting the reasons for the request.

Section 10.03 Provider Management Appeals (9.908 C)

A Provider Management Appeal means that an eligibility technician at your facility has found that the client's initial rating was inaccurate. Provider Management Appeals can result in higher or lower ratings depending on the documentation. A client has 15 days from the date of completing the application to request a Provider Management Appeal. If this time frame is not met and there was not a death in the client's immediate family, you do not have to review a Provider Management Appeal. However, please notify the client that the Provider Management Appeal was denied because the client did not submit the request by the deadline.

A client can request a Provider Management Appeal for the following reasons:

1. The initial rating contains inaccurate information or miscalculations because the family member or representative was uninformed, OR

2. Miscommunication between the client and the rating technician caused incomplete or inaccurate data to be recorded on the Application.

Each provider must designate a manager to review client appeals and grant management exceptions. A provider management appeal involves receiving a written request from the client and reviewing the application completed by the rating technician, including all back-up documentation, to determine if the CICP Application is accurate. Your facility must notify clients in writing of the results of provider management appeals within 15 working days of receipt of the appeal request from the client.

If the designated manager finds that the initial application is not accurate, the designated manager must correct the Application and assign the correct rating to the client. The correct rating is effective retroactive to the initial date of application. This means that charges incurred 90 days prior to the initial date of application must be discounted. If the initial application is accurate, the designated manager may grant a management exception to the client.

Section 10.04 Provider Management Exception (8.908 D)

A provider management exception means that the client has an unusual circumstance. Provider management exceptions must always result in a lower client rating. **Provider management exceptions should not be used for applicants who do not qualify for the CICP because their resources exceed the limit. (As an example, applicants earning $100 over income limit).** Clients can either request provider management exceptions when requesting a provider management appeal, or within 15 days from receipt of a provider management appeal notice. If this time frame is not met, the provider does not have to review the provider management exception request. However, please notify the client in writing that the provider management exception was denied because the client did not submit the request by the deadline.

Your facility must notify clients in writing of the results of provider management exceptions within 15 working days of receipt of the exception request from the client.

Designated managers can authorize a three-month exception to a client's rating based on unusual circumstances. After the 90-day period ends, the client must be re-rated. You must note provider management exceptions on the Application and the designated manager must initial the Application. The number of provider management exceptions granted by a provider cannot exceed 5% of all ratings performed. Providers must treat clients equitably in the provider management exception process.

Ratings from a provider management exception are effective retroactive to the initial date of application. This means that charges incurred 90 days prior to the initial date of application must be discounted. CICP providers do not need to honor exceptions made by other CICP providers.

Section 10.05 CICP Administration Appeals (8.908)

The Department has determined that the CICP is NOT a "covered entity" under the Health Insurance Portability and Accountability Act of 1996 privacy regulations (45 C.F.R. Parts 160 and 164). Because the CICP is not a part of Medicaid, and its principal activity is the making of grants to providers who serve eligible persons who are medically indigent, CICP is not considered a covered entity under HIPAA. The state personnel administering the CICP will provide oversight in the form of procedures and conditions, to ensure funds provided are being used to serve the target population, but **they will not be significantly involved in any health care decisions or disputes involving a qualified health care provider or client**.

HIPAA prevents the CICP Administration from being involved in client issues due to the Personal Health Information (PHI) clause. Each provider should establish procedures at their facility that sets forth the manner for handling appeals. The applicant should also be notified of these procedures.