COLORADO INDIGENT CARE PROGRAM

FISCAL YEAR 2008

MANUAL

SECTION IV:

CICP REGULATIONS

EFFECTIVE: JULY 1, 2007

8.900 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 the Medicaid Program 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 and is at 26-15-101, et seq., C.R.S., the "Reform Act for the Provision of Health Care for the Medically Indigent."

The CICP does not offer a specified discounted medical benefit package or an entitlement to medical benefits or funding to individuals or medical providers. The CICP does not offer a health coverage plan as defined in Section 10-16-102 (22.5), C.R.S. Medically indigent persons receiving discounted health care services from qualified health care providers are subject to the limitations and requirements imposed by article 15, title 26, C.R.S.

8.901 DEFINITIONS

A. "Applicant" means an individual who has applied at a qualified health care provider to receive discounted health care services.

B. "Client" means an individual whose application to receive discounted health care services has been approved by a qualified health care provider.

C. "Emergency care" is 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 26-15-103, C.R.S.

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

E. "General provider" means any general hospital, birth center, community health clinic licensed or certified by the Department of Public Health and Environment pursuant to section 25-1.5-103(1)(a)(I) or (1)(a)(II), C.R.S., any health maintenance organization issued a certificate authority pursuant to section 10-16-402, C.R.S., and the University of Colorado Health Sciences Center when acting pursuant to section 26-15-106(5)(a)(I) or (5)(a)(II)(A), C.R.S. For the purposes of the program, "general provider"

includes associated physicians.

F. "Qualified health care provider" means any general provider who is contracted with the Department to provide, and receive funding for, discounted health care services under the Colorado Indigent Care Program.

G. "Hospital provider" means any "qualified health care provider" that is a general hospital licensed or certified by the Department of Public Health and Environment pursuant to C.R.S. § 25-1.5-103 and which operates inpatient facilities.

H. "State-owned hospital provider" is any "hospital provider" that is either owned or operated by the State.

I. "Local-owned hospital provider" is any "hospital provider" that is either owned or operated by a government entity other than the State.

J. "Private-owned hospital provider" is any "hospital provider" that is privately owned and operated.

8.902 DISCOUNTED HEALTH CARE SERVICES

A. Funding provided under the CICP shall be used to provide clients with discounted health care services determined to be medically necessary by the qualified health care provider.

B. All health care services normally provided at the qualified health care provider should be available at a discount to clients. If health care services normally provided at the qualified health care provider are not available to clients at a discount, clients must be informed that the services can be offered without a discount prior to the rendering of such services.

C. Qualified health care providers receiving funding under the CICP shall prioritize the use of funding such that discounted health care services are available in the following order:

1. Emergency care;
2. Urgent care; and
3. Any other medical care.

D. Additional discounted health care services may include:

1. Emergency mental health services if the qualified health care provider renders these services to a client at the same time that the client receives other medically necessary services.

2. Qualified health care providers may provide discounted pharmaceutical services. The qualified health care provider should only provide discounted prescriptions that are written by doctors on its staff, or by a doctor that is under contract with the qualified health care provider. Qualified health care providers shall exclude prescription drugs included in the definition of Medicare Part-D from eligible clients who are also eligible for Medicare.

3. Qualified health care providers may provide a prenatal benefit with a predetermined copayment designed to encourage access to prenatal care for indigent women. This prenatal benefit shall not cover the delivery or the hospital stay, or visits that are not related to the pregnancy. The qualified health care provider is responsible for providing a description of the services included in the prenatal benefit to the client prior to services rendered. Services and copayments may vary among sites.

E. Excluded Discounted Health Care Services

Funding provided under the CICP shall not be used for providing discounted health care services for the following:

1. Non-urgent dental services.
2. Nursing home care.
3. Chiropractic services.
4. Sex change surgical procedures.
5. Cosmetic surgery.
6. Experimental and non-FDA approved treatments.
7. Elective surgeries that are not medically necessary.
8. Court ordered procedures, such as drug testing.
9. Abortions – Except as specified in Section 26-15-104.5, C.R.S.
10. Mental health services in clinic settings pursuant to 26-15-111, C.R.S., part 2 of article 1 of title 27, C.R.S., any provisions of article 22 of title 23, C.R.S., or any other provisions of law relating to the University of Colorado Psychiatric Hospital.

8.903 PROVISIONS APPLICABLE TO QUALIFIED HEALTH CARE PROVIDERS

A. Contract Requirements for Qualified Health Care Providers

1. A contract will be executed between the Department and Denver Health for the purpose of providing discounted health care services to the residents of the City and County of Denver, as required by 26-15-106 (5)(a)(I), C.R.S.

2. A contract will be executed between the Department and University Hospital for the purpose of providing discounted health care services in the Denver metropolitan area and complex care that is not contracted for in the remaining areas of the state, as required by (5)(a)(II), C.R.S.

3. Contracts may be executed with general providers throughout Colorado that can meet the following minimum criteria:

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

   b. Hospital providers shall assure that emergency care is available to all clients throughout the contract year.

   c. Hospital providers shall have at least two obstetricians with staff privileges at the hospital provider who agree to provide obstetric services to individuals under Medicaid. In the case where a hospital provider is located in a rural area (that is, an area outside of a metropolitan statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital provider to perform non-emergency obstetric procedures. The rule does not apply to a hospital provider in which the inpatients are predominantly under 18 years of age or which does not offer non-emergency obstetric services as of December 21, 1987.

   d. If the general provider is located within the City and County of Denver, the general provider must offer discounted specialty health care services to a specific population, of which more than 50% must reside outside the City and County of Denver (does not apply to University Hospital or Denver Health).

B. Determination of Client Eligibility to Receive Discounted Health Care Services Under Available CICP Funds

1. Using the information submitted in connection with an application to receive discounted health care services under available CICP funds, the provider shall determine whether the applicant meets all requirements to receive discounted health care services under available CICP funds. If the applicant is eligible to receive discounted health care services under available CICP funds, the qualified health care provider shall determine an appropriate rating and copayment for the client, using the current federal poverty levels (referred to as the ability-to-pay scale) and copayment table, under section 8.907 in these regulations.

2. The qualified health care provider should determine if the applicant is eligible to receive discounted services under available CICP funds at the time of application, unless required documentation is not available. The qualified health care provider shall determine whether the applicant is eligible to receive discounted health care services within 15 days from the date that the applicant submits a signed application and such other

information, written or otherwise, as is necessary to process the application.

3. The qualified health care provider shall provide the applicant and/or representative a written notice of the provider's determination as to the applicant's eligibility to receive discounted services under available CICP funds. If eligibility to receive discounted health care services is granted by the qualified health care provider, the notice shall include the date when eligibility began. If eligibility to receive discounted health care services is denied, the notice shall include a brief, understandable explanation of the reason(s) for the denial. Every notice of the qualified health care provider's decision, whether an approval or a denial, shall include an explanation of the applicant's appeal rights found at Section 8.908 in these regulations.

C. Distribution of Available Funds to Providers

1. Distribution of available funds to qualified health care providers (providers) is limited by the annual legislative appropriation and funds will be proportionately allocated to providers based on the anticipated utilization of services. Payments made under this section to state-owned and local-owned hospital providers will consist of Certification of Public Expenditure (see 8.903.C.3) and federal funds, as determined by the federal financial participation (FFP) amount. Payments made under this section to private-owned hospital providers will consist of General Fund and federal funds, as determined by the FFP amount.

Hospital providers who participate in the Colorado Indigent Care Program and whose percent of Medicaid-eligible inpatient days relative to total inpatient days is equal to 1% or greater, qualify to receive a Low-Income payment and a High-Volume payment. In addition, local-owned hospital providers with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and those state-owned hospital providers whose percent of Medicaid-eligible inpatient days relative to total inpatient days that equal or exceed one standard deviation above the mean, participate in the Colorado Indigent Care Program, and report Bad Debt to the Colorado Health and Hospital Association, qualify for a Bad Debt payment if funding exists.

To receive a Low-Income payment, hospital providers must have at least two obstetricians with staff privileges at the hospital provider who agree to provide obstetric services to individuals under Medicaid. In the case where a hospital provider is located in a rural area (that is, an area outside of a metropolitan statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital provider to perform non-emergency obstetric procedures. The rule does not apply to a hospital

provider in which the inpatients are predominantly under 18 years of age or which does not offer non-emergency obstetric services as of December 21, 1987.

2. Distribution of available funds for indigent care costs will be calculated based upon historical data. Third-party liabilities and the patient liabilities will be deducted from total charges to generate medically indigent charges. Available medically indigent charges are converted to medically indigent costs using the most recent provider specific audited cost-to-charge ratio available as of March 1 of each fiscal year. Medically indigent costs are inflated forward to the budget year using Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average for the second half of the previous calendar year. The basis for this calculation will be data published by the Colorado Indigent Care Program in its most recent available annual report available before rate setting by the Department for each upcoming State fiscal year.

3. Annually, state-owned and local-owned hospital providers shall submit a letter to the Department which states the cost not directly compensated by General Fund or Federal Funds for Medicaid inpatient hospital services and medically indigent services associated with the distribution of available funds. (Referred to as Certification of Public Expenditures.)

4. Providers will be notified of the distribution amounts for each State fiscal year no later than thirty (30) days prior to July 1 of each State fiscal year. The Department will notify the provider, without prior notice, of any changes in the distribution amounts applicable to the provider for a current State fiscal year that occur after July 1 of that State fiscal year.

5. Providers shall deduct amounts due from third-party payment sources from total charges declared on the summary statistics submitted to the Department concerning the use of CICP funding.

6. Providers shall deduct the full patient liability amount from total charges, which is the amount due from the client as identified in the CICP Copayment Table, as defined under Section 8.907 in these regulations. The summary information submitted to the Department concerning the use of CICP funding by the provider shall include the full patient liability amount even if the provider receives the full payment at a later date or through several smaller installments or no payment from the client.

7. Beyond the distribution of available funds made by the CICP, allowable client copayments, and other third-party sources, a provider shall not seek payment from a client for the provider's CICP discounted health care services to the client.

8. High-Volume Payment. This payment is an allocation of the available Medicare Upper Payment Limit and is available only to hospital providers. As required by federal regulations, there would be three allotments of the upper payment limit: state-owned, local-owned, and private-owned hospital providers.

   The amount of available funds under the Medicare Upper Payment Limit is distributed by the facility specific Weighted Medically Indigent Costs relative to the sum of all the Weighted Medically Indigent Costs for qualified hospital providers. This calculation would be separate for state-owned, local-owned, and private-owned hospital providers, since the three groups are limited to unique pools of funds.

   The available funds under the Medicare Upper Payment Limit are multiplied by the hospital provider specific Weighted Medically Indigent Costs divided by the sum of all Weighted Medically Indigent Costs for qualified hospital providers to calculate the High-Volume payment for the specific hospital provider. The available funds under the Medicare Upper Payment Limit by hospital provider category are:

   a. Private-Owned Hospital Providers. The General Fund and FFP available and allocated by the Department under the Medicare Inpatient Upper Payment Limit for private-owned hospital providers.

   b. Local-Owned Hospital Providers. The Certification of Public Expenditure and FFP available under the Medicare Inpatient Upper Payment Limit for local-owned hospital providers.

   c. State-Owned Hospital Providers. The Certification of Public Expenditure and FFP available under the Medicare Inpatient Upper Payment Limit for state-owned hospital providers.

   No payment (consisting of Federal Funds and General Fund or Certification of Public Expenditure) to a Local-Owned Hospital or State-Owned Hospital Provider will exceed 100% of uncompensated Medicaid inpatient hospital costs. Any amount of the calculated High-Volume payment that exceeds the calculated uncompensated Medicaid inpatient hospital costs will be added to the Low-Income payment calculation for that hospital provider. Uncompensated Medicaid inpatient hospital costs will be the maximum of the calculation of billed charges from inpatient claims paid in the most recently available State fiscal year multiplied by the cost-to-charge ratio available as of March 1 of each fiscal year

minus the Medicaid reimbursement paid amount from inpatient claims paid in the same period, or the uncompensated Medicaid inpatient hospital costs from the prior State fiscal year, as reported under 8.903(C)(3) in these regulations, such that both figures will be inflated forward to the request budget year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average for the second half of the previous calendar year.

9. Low-Income payment. This payment is an allocation of the available Disproportionate Share Hospital Allotment imposed by the federal Centers for Medicare and Medicaid Services and is only available to hospital providers. The Disproportionate Share Hospital Allotment (or Cap) would be distributed by the facility specific Weighted Medically Indigent Costs relative to the sum of all the Weighted Medically Indigent Costs for hospital providers. This calculation is separate for public-owned (state-owned and local-owned) and private-owned hospital providers, since the two hospital provider categories have unique pools of General Fund appropriated each fiscal year.

   As required by the Social Security Act, Sec. 1923(g)(1)(A), no payment (consisting of Federal Funds and General Fund or Certification of Public Expenditure) to a hospital provider will exceed 100% of Medically Indigent costs. No hospital provider will receive a payment greater than hospital provider specific inflated medically indigent care costs or the uncompensated medically indigent costs as required under 8.903(C)(3). If the calculation generates a hospital provider specific payment beyond either of these amounts, the federal funds will remain under the Disproportionate Share Hospital Allotment.

   The available Disproportionate Share Hospital Allotment is multiplied by the hospital provider specific Weighted Medically Indigent Costs divided by the sum of all Weighted Medically Indigent Costs for hospital providers to calculate the Low-Income payment for the specific hospital provider category.

   a. Private-Owned Hospital Providers. The available Disproportionate Share Hospital Allotment for private-owned hospital providers equals the General Fund and FFP available and allocated by the Department under the Disproportionate Share Hospital Allotment for private-owned hospital providers.

   b. Public-Owned Hospital Providers. The available federal funds Disproportionate Share Hospital Allotment for public-owned (state-owned and local-owned) hospital providers equals the Disproportionate Share Hospital Allotment minus other federal funds designated as a Disproportionate Share Hospital payment under another payment and the amount of the federal funds distributed to the private-owned hospital providers.

10. Weighted Costs, High-Volume Payment and Low-Income Payment.

The hospital provider specific medically indigent costs are increased by the percent of Medicaid-eligible inpatient (fee-for-service and managed care) days relative to total inpatient days and percent of medically indigent days relative to total inpatient days to measure the relative Medicaid and low-income care to total care provided. For state-owned hospital providers, these percentages are not allowed to exceed one standard deviation above the mean for each weight.

The hospital provider specific medically indigent costs are further increased by the Disproportionate Share Hospital Factor, if the hospital provider qualifies, to account for disproportionately high volumes of Medicaid. To qualify for the Disproportionate Share Hospital Factor, the hospital provider's percent of Medicaid-eligible inpatient days relative to total inpatient days must equal or exceed one standard deviation above the mean. If the hospital provider does qualify, then the Disproportionate Share Hospital Factor would equal the hospital provider's specific percent of Medicaid-eligible inpatient days relative to total inpatient days. For local-owned hospital providers with less than or equal to 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and private-owned hospital providers, the Disproportionate Share Hospital Factor is doubled. For local-owned hospital providers with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and state-owned hospital providers, the Disproportionate Share Hospital Factor is not allowed to exceed one standard deviation above the mean. If the hospital provider does not qualify, then the Disproportionate Share Hospital Factor would equal one, or have no impact.

The hospital provider specific medically indigent costs are further increased by the Medically Indigent Factor, if they qualify, to account for disproportionately high volumes of low-income care provided. To qualify for the Medically Indigent Factor, the hospital provider's percent of medically indigent days relative to total inpatient days must exceed the mean. If the hospital provider does qualify, then the Medically Indigent Factor equals the hospital provider specific percent of medically indigent days relative to total inpatient days. For local-owned hospital providers with less than or equal to 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and private-owned hospital providers, this factor is doubled. For local-owned hospital providers with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and state-owned hospital providers, the Medically Indigent Factor is not allowed to exceed one standard deviation above the mean. If

the hospital provider does not qualify, then the Medically Indigent Factor would equal one, or have no impact.

11. Bad Debt Payment. A Bad Debt payment is made only if federal funds remain available under the Disproportionate Share Hospital Allotment (or Cap) following the distribution of the Low-Income payment and the Low-Income Shortfall payment. This payment is available to local-owned hospital providers with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and state-owned hospital providers whose percent of Medicaid-eligible inpatient days relative to total inpatient days equal or exceed one standard deviation above the mean, participate in the Colorado Indigent Care Program, and report Bad Debt to the Colorado Health and Hospital Association if funding exists.

    The amount of available federal funds remaining under the Disproportionate Share Hospital Allotment are distributed by the facility specific Bad Debt Costs relative to the sum of all Bad Debt costs for all hospital providers that qualified to receive the Bad Debt payment. Available Bad Debt charges are converted to Bad Debt costs using the most recent hospital provider specific audited cost-to-charge ratio available as of March 1 each fiscal year. Bad Debt costs are inflated forward to the budget year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average for the second half of the previous calendar year.

    Available funds under the Disproportionate Share Hospital Allotment are multiplied by the hospital provider specific Bad Debt costs divided by the sum of all Bad Debt costs for all hospital providers that qualified to receive the Bad Debt payment to calculate the Bad Debt payment for the specific hospital provider.

12. Pediatric Major Teaching Hospital Payment. Hospital providers shall qualify for additional payment when they meet the criteria for being a major teaching hospital provider and when their Medicaid-eligible inpatient days combined with indigent care days (days of care provided under the Colorado Indigent Care Program) equal or exceed 30 percent of their total inpatient days for the most recent year for which data are available. A major teaching hospital provider is defined as a Colorado hospital, which meets the following criteria:

    a. Maintains a minimum of 110 total Intern and Resident (I/R) F.T.E.'s;

    b. Maintains a minimum ratio of .30 Intern and Resident (I/R) F.T.E.'s per licensed bed;

c. Qualifies as a Pediatric Specialty Hospital under the Medicaid Program, such that the hospital provides care exclusively to pediatric populations.

d. Has a percentage of Medicaid-eligible inpatient days relative to total inpatient days that equal or exceeds one standard deviation above the mean; and

e. Participates in the Colorado Indigent Care Program

The payment will be made prior to the High-Volume payment and will equal the Major Teaching Hospital Rate multiplied by the available Medicare Upper Payment Limit for the hospital providers that qualified to receive the Pediatric Major Teaching Payment. Major Teaching Hospital Rate is set by the Department such that the payment will not exceed the appropriation set by the General Assembly.

13. To calculate the distribution of available funds to hospital providers, hospital providers shall annually submit data relating to the number of Medicaid-eligible inpatient days and total inpatient days in a form specified by the Department by April 30 of each year.

14. Colorado Health Care Services Payment. This payment is an allocation of the Colorado Health Care Services Fund and is available to community health clinics and primary care clinics operated by a qualified health care provider that provides primary care services to clients who are adults (18 years of age or older). For this section, primary care services are defined in Section 8.930.1.A of the regulations for the Comprehensive Primary/Preventive Care Grant Program.

a.. For FY 2007-08, 18% of the moneys appropriated from the Colorado Health Care Services Fund shall be allocated to Denver Health Medical Center. After the appropriation to Denver Health Medical Center, 82% of the remaining funds shall be allocated to community health clinics operated by a qualified health care provider and 18% shall be allocated to primary care clinics operated by a qualified health care provider.

b. In order to receive a payment from the Colorado Health Care Services Fund, the qualified health care provider who operates a community health clinic or primary care clinic is required to complete a Colorado Health Care Services Fund Application as issued by the Department. This application for the current state fiscal year shall be submitted to the Department by July 31 of each State fiscal year.

c. Distribution of available funds for primary care clinics operated by a qualified health care provider shall be based

upon historical data for the number of unique low-income adults who received primary care services at a primary care clinic. A qualified health care provider's distribution is calculated based on the provider's number of unique clients who are adults that received primary care services at that provider's primary care clinic relative to the total number of clients who are adults that received primary care services at a primary care clinic for all qualified health care providers. The historical data will be reported in the Colorado Health Care Services Fund Application and related to the most recently available annual report published by the Colorado Indigent Care Program prior to rate setting by the Department for each upcoming State fiscal year.

d. Distribution of available funds for community health clinics operated by a qualified health care provider shall be based upon historical data for the number of unique low-income adults who received primary care services at a community health clinic. A qualified health care provider's distribution is calculated based on the provider's number of unique clients who are adults that received primary care services at that provider's community health clinic relative to the total number of clients who are adults that received primary care services at a community health clinic for all qualified health care providers. The historical data shall be reported in the Colorado Health Care Services Fund Application and related to the most recently available annual report published by the Colorado Indigent Care Program prior to rate setting by the Department for each upcoming State fiscal year.

D. Audit Requirements

The qualified health care provider shall provide the Department with an annual audit compliance statement as specified in the CICP Manual. The purpose of the audit requirement is to furnish the Department with a separate audit report, which attests to the qualified health care provider's compliance with the use of CICP funding and other requirements for participation. In addition, the audit report will furnish verification that the qualified health care provider accurately reported to the Department Medicaid-eligible inpatient days and total inpatient days used to calculate the distribution of available funds to providers defined under 8.903(C).

E. HIPAA

The Department has determined that the Colorado Indigent Care Program (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 Colorado Indigent Care Program (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.

8.904 PROVISIONS APPLICABLE TO CLIENTS

A. Overview of Requirements

In order to qualify to receive discounted health care services under available CICP funds, an applicant shall satisfy the following requirements:

1. Be a U.S. citizen or a legal immigrant, within the meaning of 26-4-103(8.5), C.R.S.;

2. Be a resident of Colorado;

3. Meet all CICP eligibility requirements as defined by state law and procedures; and

4. Furnish a social security number (SSN) or evidence that an application for a SSN has been submitted, where required by 8.904 (D) in these regulations.

B. Citizenship or Immigration Status

An applicant must be a U.S. citizen or a legal immigrant.

1. U.S. Citizen

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

a. Born in the United States, Puerto Rico, Guam, Virgin Islands of the United States, American Samoa, and Swain's Island. A birth certificate will prove that a person was born a U.S. citizen, OR

b. Received citizenship through the naturalization process. A certificate of citizenship will prove that a person is an U.S. citizen.

2. Documented Legal Immigrant

A documented legal immigrant is a person who resides in the United States and who meets the definition of "legal immigrant" in 26-4-103(8.5), C.R.S., or who possesses acceptable documentation from the Immigration and Naturalization Service (INS).

A legal immigrant shall agree to refrain from executing an affidavit of support for the purpose of sponsoring an alien on or after July 1, 1997, under rules promulgated by the immigration and naturalization service during the pendency of such legal immigrant’s receipt of discount health care services under

available CICP funding.

3. Identification and Affidavit Requirements

a. Effective August 1, 2006, each applicant eighteen (18) years of age or older shall produce the following identification:

I. A valid Colorado Driver's License or a Colorado Identification Card, issued pursuant to Article 2 of Title 42, C.R.S;

II. A United States Military Card or a Military Dependents' Identification Card;

III. A United States Coast Guard Merchant Mariner Card;

IV. A Native American Tribal Document; OR

V. Other forms of identification or a waiver process to ensure that an individual proves lawful presence in the United States as authorized by the Executive Director of the Colorado Department of Revenue pursuant to Section 24-76.5-130(5)(a), C.R.S.

b. Effective August 1, 2006, each applicant eighteen (18) years of age or older shall execute an affidavit stating:

I. That he or she is a United States Citizen or legal permanent resident; OR

II. That he or she is otherwise lawfully present in the United States pursuant to Federal Law.

c. For an applicant who has executed an affidavit stating that he or she is an alien lawfully present in the United States under 8.904.B.3.b.II, the following shall apply:

I. Verification of lawful presence shall be made through the Federal Systematic Alien Verification of Entitlement Program operated by the United States Department of Homeland Security or a successor program designated by the United States Department of Homeland Security.

II. Until verification of lawful presence is made, the affidavit may be presumed to be proof of lawful presence.

III. The qualified health care provider shall perform the

verification of lawful presence within 30 days of completing the application.

d. Photocopies of the identification listed in 8.904.B.3.a shall be acceptable identification if the photocopies meet the following criteria:

I. A notary public must have certified on the photocopy or an attachment that individually identifies the original document that he or she saw the original document and that the photocopy is a true copy of that original; OR

II. Photocopies made by the qualified health care provider who attests in writing on the photocopy that he or she saw the original documentation and that the photocopy is a true copy of that original.

e. The qualified health care provider shall retain the documentation provided under section 8.904.B with the application.

C. Residence in Colorado

An applicant must be a resident of Colorado. A Colorado resident is a person who currently lives in Colorado and intends to remain in the state.

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

1. Maintains a temporary home in Colorado for employment reasons;

2. Meet the U.S. citizen or documented legal immigrant criteria, as defined in paragraph B of this section; and

3. Employed in Colorado.

D. Social security number(s) shall be required for all clients receiving discounted health care services under available CICP funding. If an applicant does not have a social security number, documentation that the applicant has applied for a social security number must be provided to complete the application to receive discounted health care services under available CICP funding. This section shall not apply to unborn children or homeless individuals who are unable to provide a social security number.

E. Applicants Not Eligible

The following individuals are not eligible to receive discounted services under available CICP funds***:***

1. Undocumented immigrants.

2. Individuals who are being held or confined involuntarily under governmental control in State or federal prisons, jails, detention facilities or other penal facilities. This includes those individuals residing in detention centers awaiting trial, at a wilderness camp, residing in half-way houses who have not been released on parole, and those persons in the custody of a law enforcement agency temporarily released for the sole purpose of receiving health care.

3. College students whose residence is from outside Colorado or the United States that are in Colorado for the purpose of higher education. These students are not Colorado residents and cannot receive services under the CICP.

4. Visitors from other states or countries temporarily visiting Colorado and have primary residences outside of Colorado.

5. Persons who qualify for Medicaid. However, applicants whose only Medicaid benefits are the following shall not be excluded from consideration for CICP eligibility:

   a. QMB benefits described at section 8.111.1 of these regulations;

   b. SLMB benefits described at section 8.122, or

   c. The QI1 benefits described at section 8.123.

6. Individuals who are eligible 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 qualified health care provider in the 90 days prior to the application date shall not be excluded from consideration for eligibility on a temporary basis. Once the applicant becomes enrolled in the Children's Basic Health Plan, the applicant is no longer eligible to receive discounted health care services under available CICP funding.

F. Application

1. Regular Application Process

The applicant or an authorized representative of that applicant must sign the application to receive discounted health care services submitted to the qualified health care provider within 90 calendar days of the date of health care services. If an applicant is unable to sign the application or has died, a spouse, relative, or guardian may sign the application. Until it is signed, the application is not complete, the applicant cannot receive discounted health care services under available CICP funding and the applicant has no appeal rights. All information needed by the provider to process

the application must be submitted before the application is signed.

2. Emergency Application

a. In emergency circumstances, an applicant may be unable to provide all of the information or documentation required by the usual application process. For emergency situations, the qualified health care provider shall follow these steps in processing the application:

I. Use the regular application to receive discounted health care services under available CICP funding, but check emergency application on the application.

II. Ask the applicant to give spoken answers to all questions and to sign the application to receive discounted health care services under available CICP funding.

III. Assign a discount rating based on the spoken information provided.

b. 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, the qualified health care provider must require the client to submit documentation to support all figures on the emergency application or complete a new application. If the documentation submitted by the client does not support the earlier, spoken information, the qualified health care provider must obtain a new application to receive discounted health care services under available CICP funding from the client.

c. In emergency circumstances, an applicant is not required to provide identification or execute an affidavit as specified at 8.904.B.3.a and 8.904.B.3.b.

G. Applicants

1. Any adult, over the age of 18, may apply to receive discounted health care services under available CICP funding on behalf of themselves and members of the applicant's family household.

2. If an applicant is deceased, the executor of the estate or a family member may 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.

3. The application to receive discounted health care services under available CICP funding shall include the names of all members of the applicant's family household. In determining household size, a family member of any age may be included as long as s/he receives at least 50% of his/her support from the household.

4. A minor shall not be rated separately from his/her parents or guardians unless s/he is emancipated or there exists a special circumstance as outlined in the CICP Manual. A minor is an individual under the age of 18.

H. Health Insurance Information

The applicant shall submit all necessary information related to health insurance, including a copy of the insurance policy or insurance card, the address where the medical claim forms must be submitted, policy number, and any other information determined necessary.

I. Subsequent Insurance Payments

If a client receives discounted health care services under available CICP funding, and their insurance subsequently pays for services, or if the patient is awarded a settlement, the insurance company or patient shall reimburse the qualified health care provider for discounted health care services rendered to the patient.

8.905 FINANCIAL ELIGIBILITY

General Rule: An applicant shall be financially eligible for discounted health care services under available CICP funding if the client's household income and resources (minus allowable deductions and adjustments) are no more than 250% of the most recently published federal poverty level (FPL) for a household of that size.

1. The determination of financial eligibility for applicants, also known as "the rating process," is intended to be uniform throughout Colorado. The application must be completed with the eligibility technician at the qualified health care provider's site.

2. All qualified health care providers must accept each other’s CICP Ratings, unless the provider believes that the rating was determined incorrectly or that the rating was a result of a provider management exception.

3. The rating process looks at the financial circumstances of a household as of the date that a signed application is completed.

4. CICP Ratings are retroactive for services received from a qualified

health care provider up to 90 days prior to application.

5. Every effort must be made by the qualified health care provider to obtain the necessary documentation needed concerning the applicant's financial status.

8.906 CICP RATING

The federal poverty levels or the ability-to-pay scale is divided into eleven ratings. The result of the calculated income and resources and the family household size are used to determine what percentage of the federal poverty level the family meets.

Ability-to-Pay Scale
Percentage of Federal poverty levels

CICP Rating	Percent of Federal Poverty Levels	Further Descriptions
N	40%	
A	62%	
B	81%	
C	100%	
D	117%	
E	133%	
F	159%	
G	185%	
H	200%	
I	250%	
Z	40%	Homeless Clients Only

A qualified health care provider shall assign a CICP Rating or denial, and notify the applicant of his status within five working days of the applicant completing the application to receive discounted health care services. Members of applicant's family household receiving discounted health care services under the same application shall all have the same CICP Rating.

The rating letter or letter denying the application to receive discounted health care services shall include a statement informing the applicant that s/he has 15 days to appeal the denial or CICP Rating.

The CICP Rating determines a family's copayment and client copayment annual cap. CICP Ratings are effective for a maximum of one year from the date of the rating, unless the client's financial or family situation changes or the rating is a result of a qualified health care provider management exception, according to Section 8.908 (E) of these regulations.

Any family member eligible for the Children's Basic Health Plan may only receive a CICP Rating on a temporary basis. The CICP Rating is retroactive for services received 90 days prior to the application to receive discounted health care

services and valid for a temporary basis from the application date.

A. Determining the CICP Rating

The CICP Rating of an eligible client shall be determined by matching the family's net CICP income and resources to the appropriate bracket on the ability-to-pay scale, taking into account the current federal poverty level for a household of the same size.

B. CICP Re-rating

A client is required to receive a re-rating because his/her financial or family situation has changed since the initial rating. To re-rate a client, the qualified health care provider must complete a new application. Client re-ratings affect only future charges. Therefore, bills incurred after the initial rating but prior to the re-rating shall be discounted based on the client's initial rating.

If the client requests a re-rating and can document that relevant circumstances have changed since the initial rating, the qualified health care provider must re-rate the client. Reasons that justify the client to request or require the client to receive a re-rating include but are not limited to:

1. Family income has changed significantly;

2. Number of dependents has changed;

3. An error in the calculation; or

4. The eligibility year has expired.

8.907 CLIENT COPAYMENT

A. Client Copayments - General Policies

A client is responsible for paying a portion of his/her medical bills. The client's portion is called the "client copayment". Qualified health care providers are responsible for charging the client a copayment. The maximum allowable client copayments by service are shown below in the Client Copayment Table. Qualified health care providers may require clients to pay their copayment prior to receiving care (except for emergency care).

Client Copayment Table

CICP Rating	Inpatient Hospital Copayment	Physician Copayment	Outpatient Clinic Copayment	Hospital Emergency Room and Specialty Outpatient Clinic Copayment	Prescription and Lab Copayment
N	$15	$7	$7	$15	$5
A	$65	$35	$15	$25	$10
B	$105	$55	$15	$25	$10
C	$155	$80	$20	$30	$15
D	$220	$110	$20	$30	$15
E	$300	$150	$25	$35	$20
F	$390	$195	$25	$35	$20
G	$535	$270	$35	$45	$30
H	$600	$300	$35	$45	$30
I	$630	$315	$40	$50	$35
Z	$0	$0	$0	$0	$0

There are different copayments for different service charges. The following information explains the different types of medical care charges and the related client copayments.

1. 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.

2. 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.

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

4. 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.

5. 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.

6. 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.

7. 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.

8. 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.

9. 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.

B 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.

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.

C. Client Annual Copayment Cap

1. For all CICP Ratings annual copayments for clients shall not exceed 10% of the family's net income and resources.
2. The 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 shall track their copayments and inform the provider in writing (including documentation) when they meet their annual cap. However, if a client overpays the annual cap and informs the qualified health care provider of that fact in writing, the qualified health care provider shall reimburse the client for the overpayment.

3. The client's annual cap can change during the calendar year if the CICP Rating changes during the year. All copayments made toward the old annual cap during the calendar year apply to the new cap.

4. An annual cap applies only to charges incurred after a client is eligible to receive discounted health care services, and applies only to discounted services incurred at a qualified health care provider.

D. Determining Client Copayments

The client's copayment shall be determined by matching the client's CICP rating with the corresponding rate on the CICP copayment table.

E. The patient must pay the lower of the copayment listed or actual charges.

F. Clients shall be notified at or before time of services rendered of their copayment responsibility.

G. Grants for Client Copayments

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

8.908 APPEAL PROCESS

A If an applicant or client feels that a rating or denial is in error, the applicant/client shall only challenge the rating or denial by filing an appeal with the qualified health care provider who completed the application to

receive discounted health care services under available CICP funding pursuant to this section 8.908. There is no appeal process available through the Office of Administrative Courts.

B. Instructions for Filing an Appeal

The qualified health care provider shall inform the applicant or client that s/he has the right to appeal the rating or denial if s/he is not satisfied with the qualified health care provider's decision.

If the applicant or client wishes to appeal the rating or denial of the application, the applicant or client shall submit a written request for appeal, which includes any documentation supporting the reasons for the request.

C. Appeals

An applicant or client may file an appeal if the applicant or client wishes to challenge the accuracy of his or her initial rating.

A client or applicant shall have 15 calendar days from the date of the qualified health care provider's decision to request an appeal.

If the qualified health care provider does not receive the applicant's or client's appeal within the 15 days, the qualified health care provider shall notify the applicant or client in writing that the appeal was denied because it was not submitted timely. At the discretion of the qualified health care provider and for good cause shown, including a death in the applicant's or client's immediate family, the qualified health care provider may review an appeal received after 15 days.

An applicant or client can request an appeal for the following reasons:

1. The initial rating or denial was based on inaccurate information because the family member or representative was uninformed;

2. The applicant or client believes that the calculation is inaccurate for some other reason; or

3. Miscommunication between the applicant or client and the rating technician, cause incomplete or inaccurate data to be recorded on the application.

Each qualified health care provider shall designate a manager to review appeals and grant management exceptions. An appeal involves receiving a written request from the applicant or client, and reviewing the application completed by the rating technician, including all back-up documentation, to determine if the application to receive discounted health care services under available CICP funding is accurate.

If the manager finds that the initial rating or denial is not accurate, the

designated manager shall correct the application to receive discounted health care services under available CICP funding and assign the correct rating to the applicant or client. The correct rating is effective retroactive to the initial date of application, and charges incurred 90 days prior to the initial date of application must be discounted. The qualified health care provider shall notify the applicant or client in writing of the results of an appeal within 15 working days following receipt of the appeal request from the client.

D. Provider Management Exception

At the discretion of the qualified health care provider and for good cause shown, the designated manager may grant the applicant or client a provider management exception.

A client may request and a qualified health care provider may grant a provider management exception if the client can demonstrate that there are unusual circumstances that may have affected his or her initial rating. Provider Management Exceptions shall always result in a lower client rating. Provider Management Exceptions shall not be used for applicants who do not qualify to receive discounted health care services under available CICP funding due to being over-resourced.

A client may request a provider management exception within 15 calendar days of the qualified health care provider's decision regarding an appeal, or simultaneously with an appeal.

The facility shall notify the client in writing of the qualified health care provider's findings within 15 working days of receipt of the written request.

Designated managers may authorize a three-month exception to a client's rating based on unusual circumstances. After the 90 day period ends, the client shall be re-rated. The qualified health care provider must note provider management exceptions on the application. Qualified health care providers shall treat clients equitably in the provider management exception process.

A rating from a provider management exception is effective as of the initial date of application. Charges incurred 90 days prior to the initial date of application must be discounted. Qualified health care providers are not required to honor provider management exceptions granted by other qualified health care providers.