Colorado Indigent Care Program Manual

Fiscal Year 2020-21

Section I: Eligibility

Effective July 1, 2020

CICP
Colorado Indigent Care Program

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ARTICLE I. PROGRAM OVERVIEW

Section 1.01 What is the Colorado Indigent Care Program?

The Colorado Indigent Care Program (CICP) distributes federal and state funds to partially compensate qualified health care providers for uncompensated costs associated with services rendered to the low-income 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 Health First Colorado or the Child Health Plan Plus (CHP+).

The CICP is not a health coverage plan as defined in Section 10-16-102 (34) C.R.S. The Colorado Department of Regulatory Agencies (DORA), 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 cannot be used as proof of medical insurance.

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 certain limitations and requirements. The CICP makes "it possible to use state funds to partially reimburse providers for services given to the state's non-Health First Colorado 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 25.5-3-102 C.R.S.

Section 1.02 Administration of the Program

The Colorado Department of Health Care Policy and Financing (the Department) administers the CICP by distributing funding to qualified health care providers who serve eligible persons who are low-income. The Department issues procedures to ensure the funding is used to serve the low-income population in a uniform method. Any significant departure from these procedures will result in termination of the agreement with, and the funding to, a health care provider. The legislative authority for this program was originally enacted in 1983 and can currently be found under 25.5-3-101, et seq., C.R.S., the "Reform Act for the Provision of Health Care for the Medically Indigent." State rules implementing this legislation, 10 CCR 2505-10 8.900 – 8.908, are found at the Colorado Secretary of State's website.

CICP providers are encouraged to establish policies and procedures specific to their facility that are in alignment with this manual.

- The Department 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 1.03 HIPAA (Health Insurance Portability and Accountability Act)

The CICP does not meet the definition of a covered entity or business associate under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) at 45 C.F.R. 160.103). The CICP is not a part of Health First Colorado, Colorado's Medicaid program. CICP's principal activity is the making of grants to providers who serve eligible persons who are medically indigent. 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. The CICP provider is the covered entity and shall comply with all requirements under HIPAA regarding the rights of the clients they serve. It is the responsibility of the covered entity to protect the privacy rights of clients.

Section 1.04 Provisions Applicable to Providers

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

- Licensed as a community health clinic or certified as a general hospital, maternity hospital (birth center) by the Department of Public Health and Environment (DPHE).
- A federally qualified health center, as defined in section 1861 (aa) (4) of the federal "Social Security Act", 42 U.S.C sec. 1395x (aa) (4).
- A rural health clinic, as defined in section 1861 (aa) (2) of the federal "Social Security Act", 42 U.S.C sec. 1395x (aa) (2).
- 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 Health First Colorado 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.

Providers participating in the CICP shall:

1. Treat all clients with respect and with consideration for the client's dignity and privacy;
2. Inform clients of how to express opinions, compliments or concerns, and how to make a complaint without fear of reprisal;
3. Strive to provide timely resolutions to the client's complaints or concerns;
4. Protect the privacy and confidentiality of the client's health and financial records;
5. Offer clients information on all treatment options, and allow clients to participate in decisions regarding his or her health care;

6. Notify the client of the availability of sign language and interpreter services in accordance with applicable laws and regulations, when such services are necessary;
7. Ensure the availability of program information – applications, informational materials, forms and brochures;
8. Prohibit discrimination based on race, color, national origin, sex, age or disability;
9. Upon request, provide applicants with copies of all signed worksheets and documents; and
10. Explain to the client or guardian that discounted services may vary and that a rating based on financial resources will determine their portion of the bill.

Section 1.05 Provider Application

Providers wishing to participate in the CICP must submit an application annually to the Department. The application shall be completed as directed and include all information and attachments requested. The Department will notify providers annually of their eligibility for the program. The completed and accepted application serves as the agreement between the CICP provider and the Department.

Section 1.06 Provider Discontinuation in CICP Participation

A provider that discontinues CICP participation must submit a letter 60 days prior to the termination date. The letter must include information on the provider's internal charity care program and information on how the provider plans to communicate the change and transition their current CICP clients to their charity care program. The provider must submit data covering any period they have provided services to CICP clients that has not previously been reported to the Department. The provider must comply with any audit requests made by the Department for all years that the provider participated in the CICP. These requests may be made before or after the provider's participation in the program ends. All audits must be found acceptable to the CICP before any prorated payments are released to the provider.

Section 1.07 CICP Subrogation Policy

The CICP does not have any subrogation rights concerning any settlements or judgments, but those rights are retained by the facility where the medical service was provided (the provider). The provider is obligated to make all reasonable efforts to collect amounts due from third-party coverage and applicable co-payment amounts and shall maintain auditable evidence of such efforts. The client's medical claims and service information, and any related charges, must be obtained directly from the provider and the client's attorney is obligated to request the relevant information directly from the provider. Through any settlement or judgment award, the provider has the right to recover all applicable charges related to the medical service provided, even if the initial charge was discounted under the CICP.

This document is available on line at colorado.gov/hcpf/cicp under Attorney Subrogation Policy.

ARTICLE II. SERVICES OFFERED

Section 2.01 Services Provided Under the CICP

Health care services provided to CICP clients must be medically necessary, **as determined by the CICP provider**. Medical necessity is defined in 10 CCR 2505-10, Section 8.076.1.8., and means a good or service that will, or is reasonably expected to, prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects, of an illness, injury, or disability. It may also include a course of treatment that includes mere observation or no treatment at all. The good or service must be:

i. Provided in accordance with generally accepted standards of medical practice in the United States;
ii. Clinically appropriate in terms of type, frequency, extent, site, and duration;
iii. Not primarily for the economic benefit of the provider or for the convenience of the client, caretaker, or provider; and
iv. Performed in a cost effective and most appropriate setting required by the client's condition.

The Department does not determine Medical necessity. All health care services normally provided at the facility shall be 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. Emergency services must be provided at a discount to any CICP client, even if that client resides outside the provider's service area.

Section 2.02 Excluded Services

The following services are not reimbursable through the CICP:

1. Non-urgent dental services;
2. Nursing home care;
3. Chiropractic services;
4. Sex change surgical procedures;
5. Cosmetic surgery;
6. Experimental and non-United States Federal Drug Administration 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 25.5-3-106, C.R.S.;
10. Mental health services in clinic settings pursuant to Section 25.5-3-110, C.R.S., part 2 of article 66 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.

Section 2.03 Prior Authorization Requirements

There are no prior authorization requirements associated with CICP services.

ARTICLE III. APPLICANT ELIGIBILITY FOR CICP

Section 3.01 Overview of Requirements

The Department refers to eligibility determination as "the rating process."

- The rating process takes a "snapshot" of an applicant's financial and household situations 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, or if there are applicants with other health insurance coverage, when the third-party payer has paid a claim. 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 backdate more than 90 days for special circumstances under a policy determined and set by the provider. The Department cautions providers not to backdate into periods that have already been reported, as those charges will not be able to be reported to the Department.
- 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 client's rating is "client re-rating." Clients are re-rated due to specific situations, household change, or when Management Exception rating expires. Re-rates do not apply to bills prior to the re-rate.

In general, all applicants aged 18 and older must:

1. Sign an affidavit indicating their citizenship status;
2. Provide **one** approved document to demonstrate that they are lawfully present in the country;
3. Be a resident of the State of Colorado or communicate intent to remain in Colorado;
4. Furnish a Social Security number or documentation that they have applied for one – applicants do not need to furnish a Social Security Card; and
5. Meet all other CICP eligibility requirements (related to income, etc.).

Section 3.02 Applicants Not Eligible for the CICP

1. Applicants for whom lawful presence cannot be verified.
2. An applicant in custody of a law enforcement agency. An applicant 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, or involuntarily residing at a wilderness camp under any type of governmental control. Even if the medical condition is considered "pre-existing" prior to incarceration, once the applicant is held involuntarily under any type of governmental control they are not eligible for CICP.

a. 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.

b. Parole or Probation after Incarceration: An applicant on parole or probation is eligible for CICP. Residents from all halfway houses in Colorado are eligible for CICP except for those residing at Gateway: Through the Rockies.

c. Applicants on parole must present documentation of their parole status.

d. CICP funds cannot be used to provide for medical care that the state, city, or county should otherwise be responsible for.

3. 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.

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

5. Persons who qualify for Health First Colorado or CHP+.

Section 3.03 Colorado Resident

A Colorado resident is a person who currently lives in Colorado and intends to remain in the state. If the applicant is unable to provide actual proof of Colorado residency, they are **allowed to self-declare their intent to remain in Colorado**. The following questions can be used to assist in determining if the applicant is a Colorado resident:

a. 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.

b. Is applicant employed in the state of Colorado?

c. Is there a current lease, mortgage bill, or utility bill for the applicant's primary home?

d. Does the applicant have a current Colorado Driver's License or Identification Card?

College students who are living in Colorado solely for the purpose of attending college are not considered Colorado residents and are not eligible for the CICP. These individuals would become eligible for CICP after they graduate, if they decide to remain in Colorado.

Section 3.04 Residency Code

To qualify for the CICP, the applicant must be lawfully present in the United States and a Colorado resident. Colorado residency is a separate determination from Lawful Presence.

The CICP has established residency codes to use with the application. The provider must record one of the following residency codes for each household member:

1. Colorado Resident & U.S. citizen;

2. Colorado Resident & lawfully present;
3. Migrant farm worker & U.S. citizen;
4. Migrant farm worker & lawfully present; or
5. Counted in household size only.

If household members are non-residents or eligible for Health First Colorado, they cannot receive care under the CICP but can be included in household size. Household members who are eligible for CICP but do not want to be covered under CICP may be counted in household size only. **Any non-spouse or civil union partner, non-student adult ages 18-64 must have support demonstrated or attested to in order to be included on the application.**

Determining the CICP Residency Code

To determine which residency code to record on the application, use the three steps outlined below for each household 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 lawfully present using the guidelines listed in Section 3.05 below. If the applicant is lawfully present, go to step 2. If the applicant is not a U.S. Citizen or a documented legal immigrant, they cannot receive discounted care through the CICP, but can be used to determine household size.

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

i. The applicant is a Colorado resident (see "Colorado Resident" under Section 3.04) OR

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

Step 3: Record the residency code for each household member.

Section 3.05 Lawful Presence

The Department of Revenue promulgated "Rules for Evidence of Lawful Presence" at 1 CCR 204-30, effective August 30, 2016.

All applicants 18 years and older, must sign the "Affidavit for Lawful Presence, Colorado Indigent Care Program" (Affidavit) and provide a document that demonstrates they are lawfully present in the United States. This Affidavit must be signed any time an application is completed.

A copy of the Affidavit can be found in the application section of the CICP Provider Manual. In order to complete the Affidavit, the applicant must do the following:

1. **Indicate Citizenship Status**. The applicant must indicate on the Affidavit whether he or she is a U.S. citizen, a legal permanent resident, or otherwise lawfully present in the United States.
2. **Sign the Affidavit**. Each applicant 18 years and older must sign the top portion of the Affidavit. A family member or authorized representative may do this for a deceased client.

Household members who do not apply in person must also sign the affidavit. Providers are not required to directly witness an applicant's signature. Therefore, a blank Affidavit may be sent to a non-present applicant. The signed Affidavit may be returned to the provider by mail, fax, or hand-delivered to the provider's facility.

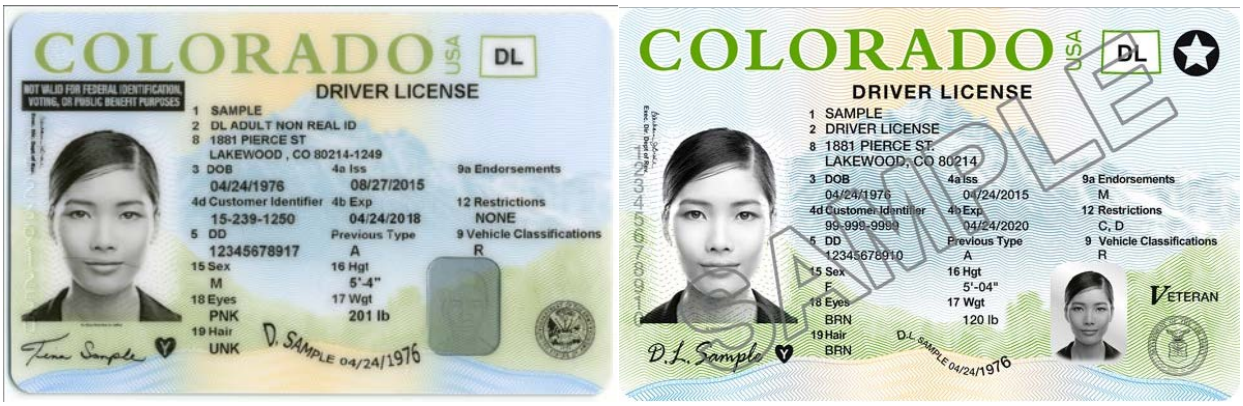
In order to prove lawful presence, the applicant must do the following:

1. **Applicants Submit One Document**. To meet the lawful presence requirement, each applicant must provide one and only one acceptable document listed in Department of Revenue's rule located at 1 CCR 204-30 Rule 5, or any document listed on a Federal list of documents acceptable to establish lawful presence. If the applicant has an ID card issued by a REAL ID Act compliant state, no other documentation is needed to prove their lawful presence. No one lawful presence document is preferred over another. All are equally acceptable.
2. **Providers Establish Lawful Presence — Not Identity**. The rules pertaining to public benefits require only the establishment of lawful presence — not identity. Thus, it is not necessary for an applicant to provide a document with a photograph.
3. **Original Documents**. Lawful presence documentation may be accepted from the applicant, the applicant's spouse, parent, guardian or authorized representative in person, by mail, or facsimile. In general, applicants should present original documentation, however copies of documentation are acceptable. Providers shall accept copies of an applicant's lawful presence documentation from other CICP providers, Medical Assistance sites, county departments of social services, or any other entity designated by the Department of Health Care Policy and Financing through an agency letter.

Providers shall develop procedures for handling original documents to ensure that the documents are not lost, damaged, or destroyed. Providers shall develop and follow procedures for returning or mailing original documents to applicants within five business days of receipt.

Applicants must provide a Colorado Driver's License, Colorado Identification Card, Driver's License or State Identification Card issued in a REAL ID compliant state (https://www.dhs.gov/real-id), United States Military Identification Card or Military Dependents' Identification Card, United States Coast Guard Merchant Mariner Card, Native American Tribal Document or any other document listed in the Colorado Department of Revenue rule for establishing lawful presence (1 CCR 204-30 Rule 5).

A sample of the new driver's license can be seen below. The license on the right is acceptable to prove lawful presence for the holder. It has the star in the upper right-hand corner that indicates the ID is REAL ID compliant and that lawful presence has been established prior to the license being issued, whether the holder is a U.S. citizen or is otherwise lawfully present in the country. The license on the left is not acceptable to prove lawful presence by itself, as indicated by the black box and white text above the picture on the license. There is also no star in the upper right-hand corner. The new state identification card has the same format as the new driver's license.



Applicants who present lawful presence documents that have an expiration date within a year of the date of the application should have their CICP card end dated with the date matching the expiration date of their presented documentation.

Section 3.06 Expired or Missing Documents from Non-U.S. Citizens

1. Expired Documents or No Documents: If an applicant who is not a U.S. citizen is unable to present any documentation evidencing his or her immigration status, the provider should refer the applicant to the local Department of Homeland Security office to obtain documentation of lawful presence status. If the applicant presents expired documents and states that they have requested new documents to replace their expired documents, the provider should attempt to run the expired documents through SAVE. If SAVE returns a valid response for the expired document, the provider is allowed to accept the expired document and associated SAVE verification as proof of lawful presence.
2. G-845 Document Verification Request: In unusual circumstances involving applicants who are hospitalized or medically disabled or who can otherwise show good cause for their inability to present documentation and for whom securing such documentation would constitute undue hardship, if the applicant can provide an alien registration number, the provider may file U.S.C.I.S. Document Verification Request Form G-845, along with the alien registration and a copy of any expired Department of Homeland Security document, with the local Department of Homeland Security office to verify status. To obtain the current G-845 Document Verification Request form, go to the U.S. Citizenship and Immigration Services website and enter G-845 in the search box. **As of June 1, 2018, this form must be filed electronically – mailed submission forms will no longer be processed.**

3. Receipt for Replacement Document: If an applicant has lost a document and presents a receipt indicating that he or she has applied to the Department of Homeland Security for a replacement document, the provider should file U.S.C.I.S. Form G-845 and Supplement with a copy of the receipt with the local Department of Homeland Security office to verify lawful presence status.

Section 3.07 Options for Applicants without Acceptable Documentation

1. **Request Waiver from Department of Revenue (DOR):** Applying for a "Request for Waiver-Restrictions on Public Benefits" from the Colorado DOR authorizes the DOR to verify evidence of lawful presence for the applicant.
   a. **Who May Apply:** Any applicant, regardless of citizenship status, who does not provide a document permissible for establishing lawful presence may apply for a Request for Waiver-Restrictions on Public Benefits" from the Colorado DOR.
   b. **Where to Find the Waiver Form:** For convenience, this Waiver may be found on the Department website at colorado.gov/hcpf/cicp under Forms, "Lawful Presence Waiver".
   c. **How to Apply:** The Waiver may be completed by the applicant or the applicant's representative. The waiver and supporting documents must be hand delivered to one of the approved driver's license offices listed on the waiver. Supporting documents may be any documents able to assist in the verification of lawful presence. If the driver's license technician does not know what to do with the applicant's documentation, the applicant should ask for their manager. DOR has confirmed that driver's license technicians should all be trained and aware of how to handle these waivers.
   d. **Affidavit of Lawful Presence:** Applicants using the waiver process must still complete the "Affidavit of Lawful Presence, Colorado Indigent Care Program" form.
   e. **Approved Waivers:** The Department of Revenue no longer notifies benefit agencies of approval or denial of waivers. Providers should require an approved waiver from Applicants before services are provided at the discount.
   f. **Special Information for Non-U.S. Citizens:** Applicants requesting a waiver who are not U.S. citizens should be made aware of the following, which is excerpted directly from The DOR's "Rules for Evidence of Lawful Presence" at 1 CCR 204-30 Rule 5, effective August 30, 2016.

      6.1 Each Benefit Agency is responsible for verifying that the Applicant is the same individual indicated as the person who received a Waiver.

      6.2 Waivers may be cancelled by the Department, if the Department subsequently determines that the Applicant was not or is not lawfully present. Upon cancelling a Waiver, the Department will notify the Applicant and appropriate Benefit Agencies.

      6.3 A person whose Waiver has been cancelled by the Department may appeal the Department's decision by requesting a hearing as provided in subsection

5.1 of this Rule within 60 days following the mailing date of the notice cancelling the Waiver.

6.4 Waivers issued by the Department since August 1, 2006, but prior to approval of this Rule, will continue in effect unless expired, or cancelled by the Department

2. **Self-Declaration of Lawful Presence**: Signing a self-declaration is a valid, acceptable way of establishing lawful presence for purposes of receiving discounted health care services under the CICP; however, the CICP Provider must first request acceptable Lawful Presence documents and it will not be necessary for the Provider to complete the shaded box on the Affidavit for Lawful Presence application. The Self-Declaration section should be used only as a last resort.
    a. **Who May Self Declare:** U.S. citizens and non-citizen nationals may self-declare that they are lawfully residing in the United States. Non-citizen nationals are defined in federal regulations as individuals from American Samoa, Swains Island, or Northern Mariana Islands.
    b. **Who May Not Self Declare:** Non-U.S. citizens may not self-declare that they are lawfully residing in the country.
    c. **Where to Find the Self-Declaration Form**: The Self-Declaration form is found under the optional section located at the bottom of the "Affidavit for Lawful Presence, Colorado Indigent Care Program" form.

Section 3.08 Non-Discrimination and Special Assistance

1. **Non-Discrimination:** CICP providers shall not discriminate against applicants on the basis of race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, or disability.
2. **Special Assistance:** If an applicant has a disability that limits the applicant's ability to provide the required evidence of lawful presence, the provider shall assist the individual to obtain the required evidence. Examples of reasonable assistance that may be expected include, but are not limited to, providing contact information for the appropriate agencies that issue required documents; explaining the documentation requirements and how the applicant may provide the required documentation; or referring the applicant to other agencies or organizations which may be able to provide assistance.

Additional assistance shall also be provided to applicants who are unable to comply with the documentation requirements due to physical or mental impairments or homelessness and who do not have a guardian or representative who can provide assistance. Examples of additional assistance include but are not limited to: contacting any known family members who may have the required documentation; contacting any known health care providers who may have the required documentation; or contacting other social services agencies or organizations that are known to have provided assistance to the applicant.

The provider is not required to pay for the cost of obtaining required documentation. The provider shall document its efforts of providing additional assistance to the applicant and retain such documentation in the applicant's file.

Section 3.09 Administrative Procedures for Documents from U.S. Citizens

1. **Indication of Documents Verified:** Providers are to check the box on the "For Eligibility Use Only" section of the Affidavit indicating which document the applicant has provided for demonstrating evidence of lawful presence.
2. **Retain Copy of Document:** A photocopy of the lawful presence document presented should be retained in the applicant's file.
3. **Exception Process for Clients Reapplying:** If a U.S. citizen reapplies for CICP with the same provider, it is not necessary to make a new copy of their lawful presence document again if the following conditions are met:
    a. The provider verifies that the document presented at the time of renewal is identical to the copy of the lawful presence already on file;
    b. The provider makes a notation in the file that the original document was viewed again and found to be acceptable; and
    c. The provider signs and dates the notation.
    d. The applicant must still sign a new Affidavit of Lawful Presence with every application.

This same process applies to providers who have electronically scanned client files.

This process may never be used for non-U.S. citizens. Lawful presence must be established for non-U.S. citizen clients each time they apply for the CICP.

Section 3.10 Administrative Procedures for Documents from Non-U.S. Citizens

If the applicant has an ID card issued by a REAL ID Act compliant state, no other documentation is needed to prove their lawful presence. A SAVE verification is not needed for these applicants.

1. **Verification of Documentation in SAVE**: Documentation submitted from applicants who have checked the second or third boxes on the "Affidavit for Lawful Presence, Colorado Indigent Care Program", indicating that they are not a U.S. citizen, must be verified through the federal Systematic Alien Verification for Entitlements (SAVE) web-based verification information system application. Providers must verify through SAVE within 30 days of receiving applications from non-U.S. citizens.
    a. **SAVE is Not for U.S. Citizens:** Only documents for non-U.S. citizens may be verified for authenticity in SAVE. It is not possible to verify documents applicable to U.S. citizens through SAVE.

b. **Use Affidavit until SAVE Verification is Complete:** Until lawful presence is confirmed in SAVE, clients are eligible to receive discounted health care services through the CICP if they have signed the Affidavit stating that they are lawfully present in the United States.

c. **No Match Found in SAVE**: In cases where a match in SAVE is not initially verified, yet the client asserts that they are legally residing in the country, the provider should begin the manual SAVE process. The provider should make the client aware of any information obtained through the SAVE process.

    i. If the manual SAVE process results in a denial, refer the applicant to the DOR to initiate the waiver process. No further services shall be discounted under the CICP until the applicant presents an approved waiver from the DOR.

    ii. The SAVE program also requires participating agencies, institutions and other entities to use manual verification when directed by a VIS/CPS system message or when the automated check or initial inspection of an applicant's/recipient's documentation, or information provided from such documentation, reveals material discrepancies. To conduct a manual verification, user agencies must electronically submit the completed Document Verification Request (Form G-845) and copies of the non-citizen's immigration documentation.

2. **Indication of Documents Verified**: Providers are to check the box on the "For Internal Use Only" section of the Affidavit indicating which document the applicant has provided for demonstrating evidence of lawful presence.

3. **Retain Copy of Document:** A photocopy of the lawful presence document presented and used in the SAVE search should be retained in the applicant's file.

4. **Retain Copy of SAVE Documentation:** Providers should print the Verification Result Screen from the SAVE search and retain this printout in the applicant's case file. The provider should make the client aware of any information obtained through the SAVE process and note such in the application file.

Section 3.11 U.S. Citizen

A U.S. citizen is a person who has signed the Affidavit of Lawful Presence, checking the line indicating that he or she is a U.S. citizen and provides one acceptable document for proving evidence of lawful presence following Department of Revenue's rule located at 1 CCR 204-30 Rule 5.

Section 3.12 Documented Immigrants

Documented immigrants are people who reside in the United States, possess a Social Security Number, and one of the lawful presence documents listed in Department of Revenue's rule located at 1 CCR 204-30 Rule 5.

Section 3.13 Migrant Workers

Migrant workers and all dependent household members who will be receiving services under the CICP must meet the following criteria to comply with CICP residency requirements:

1. Do not live permanently in Colorado; temporary living in Colorado for employment reasons;
2. Meet lawful presence requirements; and
3. Employed in Colorado. Must have proof of employment.

Eligibility is extended to dependent household members of migrant workers when the residency requirements are met for the CICP including: if the household 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 household members.

Section 3.14 Health First Colorado Programs and Child Health Plan (CHP+)

Health First Colorado is a state and federally funded program that pays for medical services for low-income households and individuals. Health First Colorado is a program for the categorically needy, meaning that an individual or household must fall below a certain income/resource limit.

CHP+ is a public health insurance for low-income children ages 18 and under and pregnant women. CHP+ is a program for applicants who are not eligible for Health First Colorado due to income limits and must not have other health insurance.

Providers must screen CICP applicants for Health First Colorado eligibility and CHP+ prior to completing a CICP rating. This is beneficial for both providers and applicants because under Health First Colorado and CHP+ providers receive higher reimbursement and applicants receive more benefits and may have lower copayments. The Provider Compliance Audit requires verification that the applicant was determined “not categorically eligible” for Health First Colorado or CHP+.

If an applicant is eligible for Health First Colorado but can provide documentation showing that they were not eligible during a period when they were provided services by a CICP provider, the applicant would be able to apply for CICP to cover only the period that they were not eligible for Health First Colorado. Their CICP card should only be valid for the period they were not eligible for Health First Colorado. These patients are commonly referred to as “churn” patients, as they routinely “churn” from eligible to not eligible for Health First Colorado, sometimes on a monthly basis.

Section 3.15 Denial of Health First Colorado or CHP+ Eligibility

If the applicant appears to meet the eligibility criteria for CHP+ or any of the Health First Colorado eligibility categories, a denial letter from CHP+, PEAK, or the local county Department of Human or Social Services must be received. A letter from Connect for Health Colorado showing that the applicant is eligible for subsidies to help reduce their

monthly premiums would also be acceptable, as applicants who are eligible for subsidies are not eligible for Health First Colorado. Denial letters from any of the above-mentioned agencies should be dated within the last 45 days.

A letter from CHP+, PEAK, or the local county Department of Human, Medical Assistance Site or Social Services indicating voluntary withdrawal or denial due to refusal to submit complete documentation is not sufficient proof that the applicant has applied for CHP+ or Health First Colorado and been denied.

ARTICLE IV. CLIENT APPLICATION

Section 4.01 Instructions for Completing the Application

This section provides acceptable practices for providers to determine household members eligible to receive discounted services for the CICP and distinguish between those only counted in household size on the application. Providers have the flexibility to define household size using policies and practices that have been submitted to and approved by the Department. Any policies in this section are mandatory for providers to follow unless marked otherwise.

When completing the CICP client application (application), the provider must obtain documentation as reasonable 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 if they have received a CICP rating with a different provider. If requested documentation is not provided by the applicant, the provider has the right to deny CICP eligibility. The applicant has a right to obtain a copy of the completed application.

Clients are responsible for notifying the provider's billing office if they have received a CICP rating from another CICP facility. Clients must report their 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. Providers are not obligated to provide a discount based on another provider's rating and may choose to re-rate any client that presents a CICP card from another CICP provider if they believe the rating process is materially different.

Section 4.02 Applicant Name

The name entered should be that of the person 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. CICP Providers can complete the application on behalf of a deceased patient only as the last remedy. The executor or family member completing the application will not be responsible for any copayments incurred on behalf of the deceased member.

Section 4.03 Applicant Address

Applicant's address refers to the residence of the applicant and his or her household members. All household members who will be receiving services under this rating must live at this address. This address cannot be a business address or an empty lot. The

household address must be the primary place where the household resides. See “Colorado Resident” under Section 3.03 for more information on the household’s primary home.

Clients who are homeless, and between 0 and 40% of the FPL, are exempt from client copayments. Homeless clients are exempt from the income verification requirement and providing proof of residency when completing the CICP application. Homeless applicants are not exempt from applying for Health First Colorado.

A person is considered homeless who lacks a fixed, regular, and adequate night-time residence or has a primary night time residency that is:

1. A supervised publicly or privately-operated shelter designed to provide temporary living accommodations;
2. An institution that provides a temporary residence for individuals intended to be institutionalized; or
3. 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 4.04 Household Member’s Name

Record the name of each household member who has or will receive care through the CICP or will be included in the household size calculation for Line 7, Section II of the application.

Determining household members to include on the application: Any person living in the household can be included on the application for purposes of determining household size. Any non-spouse or civil union partner, non-student adults under the age of 65 MUST have financial support demonstrated or attested to in order to be included on the application to receive discounted services. An applicant does not need to prove financial support for their spouse or civil union partner, any minor children, any adult students, or any adult age 65 or older living in the household. **This applies to all providers regardless if they are using their own household definition or the Department’s.**

Section 4.05 Dependency Status

Enter the appropriate Dependency Status number:

1 Self
2 Spouse/ Civil Union Partner
3 Minor
4 Senior
5 Adult Student
6 Other

1. **Married or Civil Union Couples**: BOTH spouses or partners must be included on the application. Married and Civil Union couples will receive the same CICP rating unless one of the spouses or partners is Health First Colorado eligible or an undocumented immigrant; in which case, both are still included in household size.

   A married couple means that the couple is legally married, whereas a Civil Union includes any two unmarried adults, regardless of gender. Proof of marriage is a marriage license or marriage certificate. Proof of a civil union is a certified civil union certificate. Married and Civil Union 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 spouses or partners, or either of them and in relation thereto they may be sued jointly or separately. If one spouse or partner does not want to give the necessary financial information, rate the household based on the best information available. However, inform the non-compliant spouse or partner that according to Colorado law spouses or partners are responsible for each other's medical charges.

   Married Couples wishing to separate, divorce, or have the marriage annulled must provide legal documentation of the separation, the dissolution of marriage, annulment, or declaration of invalidity to be considered separate for CICP eligibility. Parties wishing to dissolve a civil union must file an action for dissolution of a civil union, legal separation of a civil union, or declaration of invalidity of a civil union with the clerk of a court of record for the state of Colorado. For those who have not yet officially filed for a legal separation or dissolution of marriage or civil union, but intend to do so, or for those who have filed but an official court decree has not yet been issued, a letter from their attorney verifying their status will suffice. If an applicant cannot afford court associated costs, and can demonstrate to the court they are low-income, court costs owed to the state may be waived.

2. **Common Law Marriage**: If a couple meets the requirements for common law marriage, the same rules apply as with married and civil union couples as stated in Section 4.05.1. All five of the following requirements must be met for a common-law marriage in Colorado:

   a. It must be the INTENT of both parties to be spouses;

   b. Both parties must be 18 years of age or older;

   c. Both parties must be free to marry (single, widowed, or legally divorced);

   d. Both parties must live together; and

   e. 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 "household" for CICP ratings. This means both partners must complete separate applications.

- As with Married and Civil Union Couples, the spouse or partner does not have to take the other spouse or partner's last name for a common-law marriage.
- Providers may request an affidavit of Common Law Marriage signed by both parties.
- As with Married and Civil Union Couples, 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.

3. **Minors (under the age of 18):** Minors should not have an eligibility determination completed separately from their parents or guardians unless they are emancipated. Exception to this requirement is made for the following reasons:
   a. A minor who has a child and obtains medical care for the child (the minor parent is legally responsible for the cost of care);
   b. Examination and treatment for sexually transmitted diseases, including HIV;
   c. Examination and treatment for alcohol and/or drug addiction;
   d. 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 the child, that child is not considered emancipated and should be rated based on the parents' income. If the parents do not qualify for CICP, then the child cannot be covered under CICP.
   e. Voluntary mental health services, but only if the minor is fifteen years old or older;
   f. Confidential Teen Services Program - Minors in this program are rated without consideration of their parents' income under the conditions described. Therefore, when minors seek services and claim no income other than the parents' income, they will be charged the nominal or lowest copay offered. If the minor declares personal income, e.g., part-time job, that income will be used in determining their rating.
4. **Emancipated Minors:** "Emancipated juvenile", as defined in 19-1-103 (45) 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."
5. **Additional situations involving minors:**
   a. Unborn Children: Include the unborn child/children of a pregnant woman in household size on the household's application.

b. Children of Divorced Couples –In accordance with Health First Colorado policy, under CICP, children of parents who have joint custody should be counted in both parents' households.

c. 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; financial support does not need to be demonstrated for the child that is 18 years of age or older and in high school or in college. Exceptions can be made to this for Clinic providers whose household definition states that anyone 18 or older must complete their own application.

d. Disabled Children - Include a child with disabilities, regardless of age, on the parents' application if the parents support the child. If the disabled child is Health First Colorado eligible, the child cannot receive medical care through the CICP, but should be included in household size.

e. Adult Children - Adult children (defined as 18 years or older) living at home can be counted in the household size only if the entire household 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 and is not in school, the amount must be included in determining the household financial status. Adult children may submit their own application if they desire, but in this case, would not be included on the household application for income or household size.

6. **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.
7. **Household Members Outside of Colorado:** If a household member lives outside of Colorado, including in a foreign country, that individual is not a Colorado resident. However, the member can be counted in household size if the responsible party demonstrates or attests that they provide more than 50% of the member's support.
8. **Household Members Eligible for SSI, Child Support, or Foster Care:** Include household members receiving cash assistance. Household members receiving only cash assistance can receive care under the CICP if they are not Health First Colorado or CHP+ eligible.
9. **Household Members Eligible for Health First Colorado or CHP+:** Household members eligible for Health First Colorado or CHP+ cannot receive care under the CICP but can be included in the household size calculation.

Section 4.06 Date of Birth

You must enter the date of birth for all household members included in household size except for unborn children.

Section 4.07 Health First Colorado State ID Number

If any household member listed receives Health First Colorado, record the state Health First Colorado ID number on the application. If any other household member has a Health First Colorado ID and has the ID number handy, enter it on the application even if it is not currently active.

Section 4.08 Social Security Number

All applicants receiving services under the CICP must have a Social Security number entered on the CICP application. If an applicant does not have a social security number, a receipt of application for a Social Security number must be received at the time of CICP application. This does not apply to unborn children, homeless individuals who are unable to provide a Social Security number, individuals who are not eligible to receive a Social Security number, individuals who may only be issued a Social Security number for a valid non-work reason in accordance with 20 CFR 422.104, or individuals who refuse to obtain a Social Security number because of well-established religious objections. Adult, non-homeless individuals who do not have a Social Security number must indicate the reason they do not have a Social Security number on the application. A CICP provider should write only the last four digits of the applicant's Social Security number on the CICP card. Providers should be aware that any number presented as a Social Security number that begins with a "9" is not a Social Security number, it is a Taxpayer Identification Number (TIN) which is not the same and should not be treated as such.

Section 4.09 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. CICP Providers can sign the application on behalf of a deceased patient only as the last remedy. 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 responsible party does not need to be present at the facility while signing the application. The application can be mailed or emailed to the applicant for signature, and returned either by mail, email, or in person.

Section 4.10 CICP Policy on Fraudulent Applications

Clients should be notified of the following State statutes prior to signing the CICP application:

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. 18-1.3-401 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 completed the application. That notification should be in writing.

The Department should be copied on all correspondence. The Department 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 by the District Attorney or the Department.

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 Department in accordance with the CICP Manual. (See Section II: Data Collection, Article III, Section 3.05 - Previously Charged Claim Adjustments).

Section 4.11 Emergency Application

It is not always 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 the information or documentation required by the usual application process. **The CICP Emergency application should only be used for patients that appear not to be categorically eligible for Health First Colorado**. 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; and
3. Assign a CICP rating based on the verbal information provided.

An Emergency application is good for one episode of service in an emergency room and any subsequent or concurrent service (such as in inpatient hospital stay) related to that specific emergency room episode. The subsequent or concurrent service must immediately follow the emergency room service to qualify as part of an emergency episode. Treatment must be continuous to be considered part of the same emergency episode. If the client receives any care other than the emergency room visit that is not related to the emergency room episode, you must request 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. If the client does not submit any supporting documentation or complete a new application upon the request of the provider, the provider shall use the information contained in the Emergency application, however, other unrelated services shall not be discounted.

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 or episode must include a completed application accompanied by the requested documentation. The one Emergency application a year rule does not apply to any applicant who meets the definition of homeless (see CICP Regulations Section 8.907. B.a., for the definition of homeless).

Providers must allow a client to complete an Emergency application once a year when the client seeks emergency services, even if the client does not reside in the geographical area where the provider typically offers CICP discounted health care services.

Section 4.12 Health Insurance

Applicants with other medical insurance may still qualify for CICP. Therefore, applications should be completed for applicants with other medical insurance. In some cases, other medical insurance may not cover certain medically necessary benefits or applicants may have used all 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. Charges for services received up to 90 days prior to application, or in the case of applicants with other health insurance coverage, when the third-party payer has adjudicated claim, can be reported to the CICP. Applicants cannot be denied CICP if they have other insurance, and **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, even if the provider is outside of the insurance company's network.**

Attach a copy of the insurance policy or the insurance card, front and back, to the application. 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. Client liability is the payment due from third-party insurance, including Medicare. This is not payments 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.

If an applicant receives **Veterans Benefits** they may also receive CICP benefits if the following is met:

- Recipient is unable to receive a specific medical service or treatment from the Veterans Administration (VA) due to the service or treatment not being covered or not being available in a timely manner;
- Veterans Benefits have been verified. Call 1-877-222-8387 to verify health benefits; and
- If the veteran has primary insurance, they must utilize this first. The VA requests that a veteran not utilize their Veterans Benefits if they have primary insurance.

Veterans receiving authorized services from a CICP provider cannot be charged an additional CICP copayment after VA reimbursement.

Examples of Primary Insurance:

- Group Health Insurance
- Military Health Insurance
- Medicare
- Workers' Compensation
- Veterans Benefits
- HMO
- Health First Colorado
- COBRA
- Other commercial health plans

Section 4.13 FPL Determination

The CICP rating determines a household's copayments and the client's annual copayment cap. CICP ratings are effective for one year from the date of the rating unless the client's financial or household situation changes.

The "CICP Rating Box" is where you record the CICP FPL 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 working days to appeal the rating. The denial letter should clearly identify to whom the letter is addressing, with an address and phone number of the person the applicant should contact regarding the appeal. Household members receiving CICP discounted services 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 requires that the rating be effective for a shorter period of time. When a client is rated for a period less than 12 month, it is the

responsibility of the primary rating provider to perform the re-rating within the specified time.

To determine the CICP rating, complete the following steps:

On the CICP Annual Income Ranges for Each FPL Range scale, locate the appropriate household size corresponding to the household size recorded on the application.

Slide across the CICP Annual Income Ranges for Each FPL Range scale until you find the 100% FPL dollar amount. Divide the amount on the "Grand Total Net CICP Income" line of the application by the 100% FPL dollar amount and then multiply by 100 to calculate the household's FPL rating. The Excel based client application automatically calculates this rating, as does the Department developed FPL calculator.

- Households 138% (133% plus 5% disregard) and less of FPL before qualified deductions should be referred to Health First Colorado.
    - **Women who are pregnant are possibly eligible for Health First Colorado, CHP+, or other entitlement programs.** Refer those women to Health First Colorado and require them to have a denial letter prior to participating in the CICP.
- Households rated above 138% (133% plus 5% disregard) are not eligible for Health First Colorado. However, children ages 18 and younger and pregnant women age 19 and over should be referred to CHP+.
- Applicants at or below 40% of FPL who are homeless individuals, individuals living in transitional housing designed to promote self-sufficiency, individuals who have no permanent residence of their own and are temporarily residing with others who have no legal obligation to financially support them, or recipients of Colorado's Aid to the Needy Disabled financial assistance program have no required copayments. These applicants should be referred to Health First Colorado prior to approval for CICP.

Record the household's CICP FPL percentage in the "FPL Percentage" box of the application. If the household does not qualify for the CICP, write "Denied" in the "FPL Percentage" box of the application.

Give the household a copy of the completed application.

Section 4.14 Client Re-rate

Clients are re-rated due to specific situations or household changes. 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 may include one or more of the following:

1. Household income has changed significantly;
2. Number of dependents has changed;
3. An error in the calculation; OR
4. The year rate has expired.

Section 4.15 Other Provider's Rating

Providers are not required to accept each other's rates if a provider believes the rate was determined inaccurately, the person was rated incorrectly, or the other provider's rating process is materially different than yours. If a discrepancy exists, providers are asked to contact each other and arrive upon the correct rating. The Department encourages providers in the same geographical area to collaborate and come to agreements on how to handle clients rated at each other's facilities.

Section 4.16 Retention of Application Records

It is the burden of the provider of the original application to make available the applicant's application and supporting documentation for auditing for 6 State fiscal years. The original application should be housed by the original provider, and a copy of the card should suffice for any subsequent provider rendering medical services to clients screened by another CICP provider.

ARTICLE V. APPLICANT FINANCIAL ELIGIBILITY

This section provides acceptable practices for providers to determine income for applicants, but providers have the flexibility to define income using policies and practices that have been submitted to and approved by the Department. Any policies in this section that are mandatory for providers to follow will be marked as such.

The guidelines below describe how to complete the written CICP Application. If the electronic copy of the application is used, refer to instructions contained inside the Excel spreadsheet regarding usability and functionality.

Include with the applicant's application the full names, phone numbers, and addresses of all employers and monthly retirement payments. Income sources can include payments from employment, Social Security, pension funds, unemployment compensation and self-employment. List the income sources for all household members age 18 and over. Earned income from a working minor (under the age of 18) or an adult student living with their parent(s) is exempt.

Section 5.01 Determining the Applicant's Income

The Department categorizes an applicant's income into three categories. These categories are:

Line 1 – Employment Income:
Line 2 - Unearned Income; and
Line 3 - Self-Employment

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

When calculating income, you should obtain reasonable documentation to substantiate amounts.

Section 5.02 Employment Income

Employment income is income earned (including overtime, bonuses, tips, and commissions) for providing services to another individual or company. Earned income from a working minor (under the age of 18) or an adult student living with their parent(s) is exempt. Employment income for CICP does not include self-employment income which is addressed separately. Documentation of employment income can be a pay stub, a letter on official letterhead from the applicant's employer or on the CICP Provider's letterhead, or another source as determined appropriate by the provider. Providers are allowed to call the employer and get verification of the applicant's income over the phone if there is no other way available to get documentation. If providers must use this option, they should record the name of the enrollment staff that called, who they spoke to, what the position is of that person (manager, HR, etc.), and the time and date of the phone call in the notes section of the application. This option should be used as a last resort.

There are 3 steps to calculating current employment income.

Step 1. Obtain documentation for current or previous months' employment income. The rating process looks at the financial circumstances of a household as of the date a signed application is completed. If an applicant has just started a new job, for example, and has less than one month's worth of pay stubs, or has not received a paycheck yet, providers may use reasonable methods to collect information to calculate the applicant's monthly income and convert to an annual income. These methods may include obtaining a letter from the employer or calling the employer to obtain information about the applicant's pay. The Department recommends calculating the monthly income using the Year to Date Method as described below. Complete Worksheet 1 – "Earned and Unearned Income" using gross amounts. "Gross" means the dollar amount before any deductions or losses are subtracted.

Step 2. Use one of the following methods to determine the monthly gross employment income. 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 annual gross income uses the applicant's year-to-date gross earnings on the most current year-to-date pay stub. For this method, only one pay stub would be needed. To determine the annualized income, count the number of paychecks that have occurred since January 1, and then divide that number into the gross year-to-date earnings stated on the pay stub. The result of this calculation is then multiplied by the number of pay periods in a year to determine the annualized gross earnings. If the applicant has not been at their job since January 1 but you can determine how many paychecks they have received for the year, you can still use this method.

Example:

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

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

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

Average Pay Method:

The Average Pay method of calculating income uses the average gross earnings based upon the number of pay stubs provided. When using this method, the Department recommends that the provider obtain at least a full month of pay stubs from the

applicant. 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. Convert the average gross earnings to monthly income.

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

1. To convert weekly income to monthly income, multiply by 4.333
2. To convert bi-weekly (every two weeks) income to monthly income, multiply by 2.1666
3. To convert semi-monthly (twice a month) 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 and $534.00. The pay frequency is weekly. The calculation would be as follows:

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

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

Multiply: $495.50 by 4.333 = $2,147.00

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

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

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

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

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

Letter on employer's letterhead with hourly wage and hours to be worked per week:

Weekly earnings = $8.50 per hour x 20 hours per week = $170 per week

Monthly gross earnings = $170 x 4.333 = $736.61 per month

Annual income = $736.61 x 12 months = $8,839.32 per year

Monthly Pay Method:

Note that this method is only accurate for applicants with fixed salaries. Employees paid monthly on an hourly basis will likely have paychecks that vary in amount month to month. The monthly pay method of calculating income utilizes the most recent monthly pay stub. Use 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 5.03 Unearned Income

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 2 of the application. This income can be self-declared; however, Provider should use the most recent monthly amount and calculate income as annual income. Providers should have policies or procedures stating which types of unearned income they include in applicants' income calculations.

Section 5.04 Exempt Unearned Income

Providers MAY NOT include any of the following types of unearned income when determining total income:

1. Payments to recipients of Colorado's Aid to the Needy Disabled (AND) financial assistance program;
2. 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;
3. 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;
4. Child Support and Foster Care Payments. These payments are for the support of children. Many children receiving these payments are Health First Colorado eligible. Therefore, require a Health First Colorado denial before allowing these children to receive care under the CICP;
5. Food Stamps, Women, Infants and Children (WIC), and Temporary Assistance for Needy Families (TANF);
6. Assistance provided by non-profit organizations, if the assistance is need-based (i.e., the cost of meals at a soup kitchen);
7. Medical care provided for free or if a third-party made the payments;

8. Settlements received as a result of a prior medical injury; not related to the current CICP application;
9. Reimbursement for work-related personal expenses;
10. College loans;
11. Payments by credit life or credit disability insurance;
12. Proceeds of a loan;
13. Income from a reverse mortgage;
14. Disaster relief assistance;
15. Tax refunds;
16. Pensions and insurance policies (irrevocable policies) that are not available without penalty;
17. Moving expenses paid by employer for relocation;
18. Social Security income for a minor (under the age of 18);
19. Up to $2,000 per calendar year of income received by applicants of American Indian birth origin, which is derived from leases or other uses of individually-owned trusts or restricted lands pursuant to P. L 103-66 and P. L. 97-458 is exempt as income in the month received; For purposes of this provision, the exclusion of income shall be applied only to months for which an eligibility determination is being made;
20. Adoption Subsidy

Section 5.05 Self-Employment

If a self-employed applicant pays themselves just as they would their employees, and can document by pay stubs, enter the figure from the pay stub into Worksheet 1 as you would for any other employment income. In this case, Worksheet 2 would not need to be completed. For a self-employed applicant who does not pay themselves this way, Worksheet 2 must be completed, signed, dated, and attached to the application.

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, a ledger, or any other documentation the provider deems acceptable for calculating gross income and business expenses. Applicants may not write down income and expenses while at the rating appointment without providing acceptable documentation of the income and expenses. Gross income amount and business expenses listed on the accepted documentation should be transferred to Worksheet 2. An expense is something that is necessary to keep a business in operation. Providers are allowed to set their own policy describing which expenses to count for self-employed applicants.

1. Self-employment expenses must 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.

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

Example:

A subcontractor works out of his primary residence. The subcontractor's gross monthly income is $2,000. Eight hundred square feet of the 2400 square foot home is for the business and the applicant runs their business for 60 hours of the week. Other household activities occur in the business space when the applicant is not working.

$$\left(\frac{business\ square\ footage}{total\ square\ footage}\right) * \left(\frac{hours\ per\ week\ used\ for\ business}{total\ hours\ in\ week}\right)$$

$$= \left(\frac{800 sqft}{2400 sqft}\right) * \left(\frac{60\ hours}{168\ hours}\right) = .3333 * .357 = .119$$

The household expenses are as follows:

- Internet $45
- Phone $50
- Mortgage $900
- Utility $100
- Supplies $60
- Internet $45

Subcontractor uses 75% of the internet for the business. $45 multiplied by .75 = **$33.75**

$33.75 is the amount used for business expense

Mortgage $900 Subcontractor works from primary residence, deduct .119 as expense

$900 * .119 = **$107.10**

$107.10 is the amount used for business expense

Utility $100 Subcontractor works from primary residence, deduct .119 as expense

$100 * .119 = **$11.90**

$11.90 is the amount used for business expense

Phone $50	Subcontractor has a separate business telephone. Count entire expense for business purposes - **$50**
Supplies $60	Subcontractor only uses supplies for business purposes. Count entire expense for business purposes - **$60**

Total Monthly Business Expenses: $262.75

Total Monthly Gross Income: $2,000.00

Subtract $2,000.00 - $262.75 = $1,737.25 (monthly)

Annualize $1,737.25 x 12 months =$20,847.00 (yearly)

Write the annualized self-employment income on Line 3 of the application.

Section 5.06 Short-Term Disability or Unemployment

Applicants who are on short-term disability or are receiving unemployment income are unique cases and should be treated as such. For clarification, short-term disability and unemployment incomes should only be counted if the applicant is currently receiving them (or will be soon, in the case of short-term disability). If the applicant received either type of payment earlier in the year but is back to being employed full time, that income should not be considered as part of their income determination going forward since they are no longer receiving it. CICP looks at the applicant's current situation and calculates the next 12 months (365 days) using that information, so it would be inappropriate to include income that is no longer impacting their situation.

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

Unemployment is temporary and has a maximum payable amount. An individual drawing unemployment can only collect money as long as they have money in their unemployment account. Individuals who are collecting unemployment are informed of the maximum payment amount, so the number of weeks they will be able to claim unemployment funds can be easily calculated. Applicants who are currently drawing unemployment funds should only be rated for the period of time that their unemployment will cover. Once this period is over, the client should be rerated as they will either have a new job or have no income at all.

Documentation should be collected for applicants in either of these situations to support their income calculation.

Section 5.07 Total Income

To calculate total income for Section II of the application, add “Gross Employment Income (line 1)” PLUS “Unearned Income (Line 2)” PLUS “Self-Employment Income (Line 3)”. Take the total from lines 1, 2, and 3, and record the amount in “Total Income (line 4)”.

Section 5.08 Liquid Resources

Liquid resources are resources that can be converted to cash immediately. Hospital providers are allowed to decide which liquid resources will be included in the CICP application for their facilities and must note those liquid resources on their annual provider application. Clinic providers are not allowed to count liquid resources for CICP applicants.

Retirement accounts and Tax-Sheltered Annuities may NOT be counted unless the applicant is receiving a monthly payment from them, in which case only the monthly amount may be counted.

If the provider is including partnerships (i.e. partnership in a farm), request the applicant’s 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.

If the provider is including Certificates of Deposit (CDs), count the principal (amount of original investment) of a CD as a resource regardless of the maturity date of the CD. All CD’s should be considered liquid. The amount included should be the amount left after the penalty for withdrawal has been subtracted. If an applicant has recently cashed a CD that has reached its maturity date, count the principal in addition to the interest earned.

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”.

Section 5.09 Less Household Size Protected Amount

The CICP protects at least $2,500 in liquid resources per household member on the client application used by hospitals. Hospital providers are allowed to protect more than $2,500 per household member, which is indicated in the annual provider application. Clinics do not count applicant resources when determining financial eligibility for the CICP. Therefore, this item does not apply to CICP clinic providers.

There are two steps to calculating the “Household Size Protected Amount”:

Step 1. Write the number of household members (including applicant) listed by the applicant in the "Household Size" section of the application.

Step 2. Multiply the household size obtained in Step 1 by your facility's protected amount (must be at least $2,500). Write this amount on the Household Size Protected Amount line.

Section 5.10 Available Resources

On the CICP application, Line 8 - "Available Resources" equals Line 6 - "Liquid Resources," MINUS Line 7 - "Less Household Size Protected Amount". If this amount is less than $0 (a negative amount), you must record $0 and not the negative amount.

Section 5.11 Total Household Financial Status

On the CICP application, the "Total Household Financial Status" line equals the "Total Income" line PLUS the "Available Resources" line.

Section 5.12 Allowable Deductions

Hospital providers are allowed to determine which deductions best fit their communities and declare those deductions each year on their annual provider application. Only the deductions listed on the annual hospital provider application can be used for applicants applying at the hospital provider.

Clinic providers are allowed to count deductions from income that are included in their board approved definition of income.

Section 5.13 Net CICP Income and Equity in Resources

The "Grand Total Net CICP Income" Line determines the amount of income to use in the CICP financial determination. The "Grand Total Net CICP Income" line equals the "Total Household Financial Status" line MINUS the "Allowable Deductions" line.

Section 5.14 Liquid Resource Spend Down

The Liquid Resource Spend Down may only be used for applicants applying with Hospital Providers who choose to include liquid resources in their financial determination process. The Liquid Resource Spend Down Provision allows applicants whose combined income and liquid resources makes them over income for the CICP. An applicant may be determined eligible if they have enough liquid resources to "spend down" or reduce their income enough to qualify for the CICP. The amount an applicant must "spend down" is the difference between the applicant's income and either the CICP eligibility standard at 250% of the Federal Poverty Level or the highest percentage the Hospital Provider serves under CICP if they elect to serve CICP clients over 250%. The "spend down" reduces the amount of liquid resources the applicant has and should be applied to a current medical bill (paid to a medical provider). Applicants may choose to pay a medical bill from a different provider to meet the spend down requirement and should present proof of the

payment before the application is completed. The remainder of the medical bill is then discounted under the CICP. The client is still responsible for the CICP copayment.

Example:

Employment income of $18,000 per year, Bank account of $16,500.

Household size of 1, the Household Size Protected Amount is $2,500

Available Resources is $16,500 – $2,500 = **$14,000**

Total household financial status is $18,000 + $14,000 = **$32,000**, 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 $31,225 (household size of 1, at 250% of Federal Poverty Level)

The liquid assets need to be reduced by $1,650 ($32,000 – $31,225 = $775).

The $775 is applied to the current medical bill of $25,000 and paid directly to the provider.

The remaining medical bill is $25,000 - $775 = **$24,225**

The client is now eligible for the CICP discount, with a total household financial status of $31,225 ($18,000 employment income and $13,225 in resources).

When reporting information on the CICP Summary Spreadsheet, the provider should record the total bill of $25,000 and the client spend down of $775 as a third-party payment.

ARTICLE VI. CLIENT COPAYMENT

Section 6.01 Client Annual Copayment and Cap

For all clients, except for clients who are between 0 and 40% of the FPL, annual copayments for CICP clients cannot exceed 10% of the household's "Grand Total Net CICP Income," recorded on the application. Annual copayments for clients who are between 0 and 40% of the FPL is 10% of their income or $120, whichever is less. For example, an applicant with an annual income of $600 would have a copayment cap of $60. Similarly, an applicant with no income would have a copayment cap of $0. An applicant with an annual income of $1,400 would have a copayment cap of $120.

CICP clients who are also Old Age Pension (OAP) Health and Medical Care Program clients have an annual copayment cap of $300 during a calendar year. Copayments these clients make for any medical service to any medical provider count against their annual copayment cap.

The CICP Client Annual Copayment Cap (annual cap) is based on the client's application date. Only copayments that have been paid can be applied to the copayment cap. Clients are responsible for any charges incurred prior to receiving their CICP rating. Copayments made for visits that are covered in the 90-day backdating period count against the annual cap. 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 is reset when the client completes a new application.

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. If the client makes copayments on services contained in the 90-day backdating period, those copays will count against the annual cap. For example: A client received services from a provider's facility in March and did not qualify for the CICP. In October and November, the client receives services from a provider's facility and qualifies for the CICP in November. Payments made by the client for the services received in March do not apply to the annual cap, but payments made for the services received in October and November do apply.

Sometimes clients want to prepay their annual cap prior to receiving services. The Department 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.

Due to the differences in rating processes from provider to provider, clients may have multiple copayment caps. While all CICP copayments count against all copayment caps, clients may reach their copayment cap with one provider before they reach their copayment cap with a second provider. Reaching a copayment cap with one provider

does not necessarily mean the client does not owe any more copayments to other providers if their caps with those providers are higher.

Section 6.02 Calculating the CICP Client Copayment Annual Cap

Providers are allowed to set the clients' annual copayment cap to any integer percentage between 1% and 10%. Lower copayment caps are more beneficial to the client. Providers who choose to lower the annual cap percentage must use the same lower percentage for all clients rated at their facility.

To calculate the "CICP Client Copayment Annual Cap," multiply the "Grand Total Net CICP Income" line of the application by the percentage chosen (between .01 and .10). Round this amount down to the next lowest dollar amount (i.e. $2,379.65 would become $2,379). Enter this amount on the "Client Copayment Annual Cap" Line in the Client Copayment box.

Example: In February, a household of four applies for the CICP. Their "Net CICP Income," is $32,000. Their CICP annual cap is $3,200 ($32,000 x 0.10). By July, the household has paid $2,700 in copayments. The mother loses her job in June, so the household can request to be re-rated. Although the client is eligible for a new rating, the copayments already paid will not count towards the new CICP copayment cap.

Section 6.03 Client Copayments General Policies

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 (unless the client is homeless and at or under 40% FPL). The Department recommends that CICP providers require clients to pay their copayment prior to receiving care (except emergent care).

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.

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:

1. The **Inpatient Facility** copayment is required for charges related to non-physician (facility) services incurred while receiving care in a hospital for a continuous stay of 24 hours or longer. For a patient seen in the hospital setting, only the hospital inpatient or emergency room copayment, plus the physician copayment can be charged. The emergency room copayment covers all services received while in the emergency department.

2. **Ambulatory Surgery** copayment is for operative procedures received by a client who is admitted to and discharged from the hospital setting on the same day.
3. The **Hospital Physician** copayment is required for charges related to services provided directly by the physician in the hospital setting, including emergency room care.
4. The **Clinic** copayment is required for charges related to non-physician (facility) **and** physician services received in the clinic setting. This includes charges for primary and preventive medical care. It does not include charges for outpatient services provided in a hospital (i.e., emergency room care, outpatient surgery, radiology). If labs or x-rays are performed in the clinic, the additional lab or radiology copayment may be added.
    - For example, if a CICP client was seen in the emergency department and had lab work done, the client would owe the emergency room copayment plus the physician copayment. If the same CICP client was seen in the Provider's primary care clinic and not the emergency room and had lab work done, the client would owe the outpatient clinic copayment plus the laboratory services copayment.
5. The **Outpatient Hospital** copayment is required for charges related to non-physician (facility) and physician services received in the outpatient hospital setting. This includes charges for primary and preventive medical care. If labs or x-rays are performed in the outpatient hospital setting, the additional lab or radiology copayment may be added.
6. The **Emergency Room** copayment is required for charges related to non-physician (facility) services incurred while receiving care in the hospital setting for a continuous stay of less than 24 hours.
7. **Specialty Outpatient Clinic** copayment is required for charges related to non-physician (facility) **and** physician services received in the specialty outpatient clinic setting but does not include charges for outpatient services provided in the hospital setting (i.e., emergency room physician, ambulatory surgery). Specialty outpatient charges include distinctive medical care (i.e., oncology, orthopedics, hematology, pulmonary) that is not normally available as primary and preventative medical care.
8. **Outpatient Pharmacy** copayment is required for prescription drugs received at a qualified CICP health care provider's pharmacy.
9. **Laboratory Services** copayment is required for charges related to laboratory tests received by the client that are not associated with an inpatient facility or emergency room charge during the same period.
10. **Basic Radiology and Imaging Services** copayment is required for charges related to radiology and imaging received by client in the clinic or specialty outpatient setting but does not include charges from emergency room or inpatient services provided in the hospital setting.

11. **High-Level Radiology and Imaging** copayment is required for charges related to a Magnetic Resonance Imaging (MRI), Computed Tomography (CT), Positron Emission Tomography (PET), Sleep Studies, Catheterization Laboratory (cath lab) or other Nuclear Medicine services in an Outpatient setting. This copayment already includes the outpatient facility charge and therefore MAY NOT be combined with any other outpatient facility charge (i.e. Emergency Room, Specialty Outpatient Clinic).
12. The **Emergency Transportation** copayment is required for charges related to emergency transportation/ambulance services from CICP providers approved to discount such services.
13. The CICP definition of homeless encompasses clients who are at or below 40% of the Federal Poverty Level and are homeless, living in transitional housing, temporarily residing with others, or recipients of Colorado's Aid to the Needy Disabled financial assistance program.

- Clients who are homeless are exempt from client copayments.

- Clients who are homeless are exempt from the income verification requirement and providing proof of residency when completing the CICP application. Clients who are homeless are NOT exempt from the verification of denied Health First Colorado benefits requirement.

- Transitional housing clients are clients who are participating in programs designed to assist individuals in becoming self-supporting. Clients living in transitional housing must provide a written statement from their counselor or program director asserting that they are participating in a transitional housing program. Transitional housing clients are exempt from client copayments. In addition, transitional housing clients are exempt from the income verification requirement when completing the CICP application.

- Clients who have no permanent housing of their own and who are temporarily living with a person who has no legal obligation to financially support the client are exempt from client copayments. The individual allowing the client to reside with him or her may be asked to provide a written statement confirming that the client is not providing financial assistance to the household and that the living arrangement is not intended to be permanent. Clients residing with others MUST verify income and demonstrate denial of Health First Colorado benefits to be eligible for the CICP.

- Recipients of Colorado's Aid to the Needy Disabled (AND) financial assistance program who are eligible and enrolled to receive the monthly grant award are exempt from client copayments. In addition, recipients of Colorado's Aid to the Needy Disabled (AND) financial assistance program are exempt from the income verification when completing the CICP application. The majority of applicants in this category should qualify for the Expansion Health First Colorado program.

Section 6.04 Determining a Client's Copayment

Using the client rating recorded in the “CICP Rating” box on the client’s CICP card, look up the corresponding rating on the “CICP Client Copayment Table” or your Department approved sliding fee scale.

ARTICLE VII. APPEAL PROCESS

Section 7.01 Re-rating

To re-rate a client, a new CICP application must be completed.

Even though a client's financial situation may not have changed, they may 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:

1. Provider Management Appeal
2. Provider Management Exception

Section 7.02 Instructions for Filing an Appeal

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. A client can request a Provider Management Appeal and/or Exception in the same letter. Each of these methods requires the client to submit a written request and provide documentation supporting the reasons for the request.

Section 7.03 Provider Management Appeals

A Provider Management Appeal occurs when a client believes their initial rating was inaccurate. Provider Management Appeals can result in higher or lower ratings depending on the documentation. A client has 15 working 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 requested 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 household 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 7.04 Provider Management Exception

A Provider Management Exception means that the client has an unusual circumstance, which may justify lowering the CICP rating or qualifying an applicant for the CICP who was otherwise over income. Clients can either request Provider Management Exceptions when requesting a Provider Management Appeal or within 15 working 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 an exception to a client's rating based on unusual circumstances. You must note Provider Management Exceptions on the application and the designated manager must initial the application. 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 7.05 Department Appeals

HIPAA prevents the Department 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.

ARTICLE VIII. APPENDIX

Section 8.01 CICP Eligibility and Other Health Programs

The table below illustrates what program categories can be used in conjunction with CICP.

Children's Programs	Description of Programs	FPL	CICP Eligible	Effective Date:
Child Health Plan Plus (CHP+)	Low-cost health insurance for children under 19. Enrollment fees may apply	260% FPL	No	First day of month of CHP+ application.
CHP+ Presumptive Eligibility (PE)	Access to immediate temporary medical coverage for children, for at least 45 days while eligibility for full health care benefits is determined.	260% FPL	No	Coverage starts the day of application
Health First Colorado Presumptive Eligibility (PE)	Access to immediate temporary medical coverage for children, for at least 45 days while eligibility for full health care benefits is determined.	142% FPL	No	Coverage starts the day of application
Children with low-income	Health First Colorado coverage for children under 19.	142% FPL	No	Backdates up to 90 days from application date. First day of the month of application, if no backdates are requested. Five-year ban lifted as of 7-1-14.
Foster Care	Health First Colorado covers persons less than 21 years of age for whom a county is assuming full or partial financial responsibility; who are in foster care, in homes or private institutions, or in subsidized adoptive homes prior to the final decree of adoption.	N.A.	No	N.A.
Former Foster Care	Health First Colorado coverage to age 26 for youth who have aged out of foster care who were not adopted and who did not emancipate prior to turning 18.	N.A.	No	N.A.

Programs for Children with Disabilities	Description of Programs	FPL	CICP Eligible	Effective Date:
Brain Injury Waiver (BI)	Provides home or community-based alternative to hospital or specialized nursing facility care for persons with a brain injury. Must be 16 years of age or older.	300% SSI	No	
Children with Life Limiting Illness Waiver (CLLI)	Provides home or community-based alternative to children under 19 with a life limiting illness.	300% SSI	No	
Children's Extensive Support Waiver (CES)	Provides supports and services to children with developmental disabilities or delays who have a complex behavioral or medical condition and who require near constant line of sight supervision. Must be 18 years of age or younger.	300% SSI	No	
Children's Habilitation Residential Program Waiver (CHRP)	Provides habilitative services for children and youth in foster care who have a developmental disability and extraordinary needs.	N.A.	No	
Children's Home and Community-Based Services Waiver (CHCBS)	Provides home or community-based alternative to children 17 years of age and younger with significant medical needs who are at risk for acute hospital or skilled nursing facility placement.	300% SSI	No	
Family Support Services Program (FSSP)	Provides support for families who have children with developmental disabilities or delays with costs that are beyond those normally experienced by other families.	N.A.	No	
Health First Colorado Buy-In Program for Children with Disabilities	Buy-In for children 19 and under with a disability by paying a monthly premium based on the family's income.	300% FPL	No	

Pregnant Women Programs	Description of Programs	FPL	CICP Eligible	Effective Date
CHP+	Low-cost health insurance for pregnant women. Enrollment fees may apply.	260% FPL	No	First day of month of CHP+ application.
CHP+ Presumptive Eligibility	Access to immediate temporary medical coverage for pregnant women for at least 45 days, while eligibility for full health care benefits is determined.	260% FPL	No	Coverage starts the day of application
Health First Colorado Presumptive Eligibility (PE)	Immediate temporary Health First Colorado coverage for pregnant women.	195% FPL	No	Coverage starts the day of application
Health First Colorado	Health First Colorado coverage for pregnant women.	195% FPL	No	Backdates up to 90 days of application.

Health First Colorado Programs for Adults	Description of Programs	FPL	CICP Eligible	Effective Date
Transitional Medical Assistance	Ineligible for Health First Colorado because new or increased income from employment, or hours of employment, provided an employed member of household continues to be employed.	185% FPL	No	Begins first month of ineligibility for Health First Colorado due to change in income.
Transitional Medical Assistance (4 Month Extended)	Ineligible for Health First Colorado because alimony income	185% FPL	No	Begins first month of ineligibility for Health First Colorado due to change in income.
Caretaker of Dependent Children	Adults age 19 through 64. Must have dependent child in home.	133% FPL	No	Backdates up to 90 days of Health First Colorado application.
Health First Colorado for Adults	Adults age 19 through 64 without a dependent child in the home.	133% FPL	No	Backdates up to 90 days from Health First Colorado application.

Programs for Adults with Disabilities	Description of Programs	FPL	CICP Eligible	Effective Date
Brain Injury Waiver (BI)	Provides home or community-based alternative to hospital or specialized nursing facility care for persons with a brain injury. Must be 16 years of age or older.	300% SSI	No	
Colorado Choice Transitions (CCT)	Helps transition Health First Colorado members out of nursing homes and long-term care facilities and into home and community-based settings.	133% FPL	No	
Community Mental Health Supports Waiver (CMHS)	Provides home or community-based alternative to nursing facility care for people with major mental illness.	300% SSI	No	
Developmental Disabilities Waiver (DD)	Provides people with developmental disabilities services and supports that allow them to continue living in the community.	300% SSI	No	
Elderly, Blind, & Disabled Waiver (EBD)	Provides an alternative to nursing facility care for elderly, blind, or physically disabled persons, as well as individuals living with HIV/AIDS.	300% SSI	No	
Family Support Services Program (FSSP)	Provides support for families who have children with developmental disabilities or delays with costs that are beyond those normally experienced by other families.	N.A.	No	
Health First Colorado Buy-In Program for Working Adults with Disabilities	Buy-In for adults who are 16 through 65 years of age, employed, and have a qualifying disability. Monthly premium based on the family's income.	450% FPL	No	Backdates up to 90 days from Health First Colorado application
Spinal Cord Injury Waiver (SCI)	Provides home or community-based alternative for people with a spinal cord injury in the Denver Metro Area	300% SSI	No	

Programs for Adults with Disabilities	Description of Programs	FPL	CICP Eligible	Effective Date
Supported Living Services Waiver (SLS)	Provides supported living in the home or community to persons with developmental disabilities	300% SSI	No	

Senior Adult Programs	Description of Programs	FPL	CICP Eligible	Effective Date
Old Age Pension (OAP)-A and B-Medical	Disabled or 65 and over. Financial payment entitles clients for a category of Medical Assistance, either Health First Colorado or Health Care Program.	76.9% FPL	No	Backdates up to 90 days from Health First Colorado application.
Old Age Pension (OAP-State Only) and HCP-B State Only	Not eligible for Health First Colorado.	76.9% FPL	Yes	Eligibility begins date of application or date eligibility is established, whichever is later.

Medicare Savings Programs (MSP)	Description of Programs	FPL	CICP Eligible	Effective Date
Specified Low-Income Medicare Beneficiary Program (SLMB)	State pays for Medicare Part B premiums.	Monthly income of $1,234 for individuals, $1,666 for couples	Yes	Backdates up to 90 days from application.
Qualified Individual Program (QI1)	State pays for Medicare Part B premiums. Granted on a first-come, first-served basis with priority for people who received QI the previous year.	Monthly income of $1,386 for individuals, $1,872 for couples	Yes	Backdates up to 90 days from application.

Medicare Savings Programs (MSP)	Description of Programs	FPL	CICP Eligible	Effective Date
Qualified Disabled and Working Individual (QDWI)	State pays for Medicare Part A premium. Must be working disabled person under age 65 and not receiving other medical assistance from the state	Monthly income of $2,044 for individuals, $2,764 for couples	Yes	
Qualified Medicare Beneficiary Program (QMB)	State pays for Part A and B premiums and Medicare deductibles, coinsurance, and copays.	Monthly income of $1,032 for individuals, $1,392 for couples	Yes	Effective 1st day of month following the month of eligibility determination.
Medicare-Health First Colorado –QMB (Dual Eligible)	65 years or older, disabled status under Social Security, or Railroad Retirement assistance with Medicare premiums and out of pocket Health First Colorado expenses.	100% FPL	No	Effective 1st day of month following the month of eligibility determination.