Copayment Policies

2020-21 CICP Training

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Objectives

- Copayment cap and calculations
- Copayment general policies
- How to calculate client copayments due

Annual Copayment Cap

- Annual copayment cap (annual cap) cannot exceed 10% of the Client's annual income
- For Clients who are homeless and fall between 0 and 40% FPL, their annual cap is $0 since the copayments for the homeless category are $0
  - For Clients who are homeless and above 40% FPL, the 10% rule applies
- For Clients who are not homeless and fall between 0 and 40% FPL, their annual cap is 10% of their income or $120, whichever is less

Examples

- For a household with an annual income of $600, the annual cap would be $60.
- For a household with an annual income of $1,400, the annual cap would be $120.
- For a household with no income, the annual cap would be $0 and the household would have "met" their annual cap immediately and therefore have $0 copays.
  - $0 x 10% = $0

Old Age Pension (OAP)

- Some CICP Clients may also be OAP clients
- Per the OAP rules, these Clients have an annual cap of $300 for ALL medical services they receive
  - This means that their copays for services not covered by CICP also count towards their annual cap
- Their annual cap runs on a calendar year basis, unlike other CICP Clients
- Providers need to be aware if the Client is an OAP client and make sure to adjust their cap appropriately

Effective Dates

- The annual cap is based on the household's application date and is valid for a year at longest
- The annual cap resets if a household is rerated prior to their original end date
  - Rerates only impact copays due on future services and do not change the copays due on previous services

Meeting the Cap

- Annual caps apply to charges incurred after a Client is eligible for the CICP and only for services that are discounted under the program at a CICP provider facility
- Payments made on services in the 90 day backdating period count against the annual cap
- Households are responsible for tracking their copayments and informing providers they have met their annual cap
  - Providers must return any overpaid copayments if the household informs them they overpaid their annual cap

Multiple Annual Caps

- Due to the fact that providers are allowed to decide which unearned income sources, deductions, and liquid resources are counted at their facility, it is probable that households rated at two different facilities will have different FPLs and different annual caps
- A household may meet their annual cap at one provider and still owe copayments to the second provider

General Policies

- CICP Clients are responsible for paying a portion of their medical bills
- Clients must be charged a copayment for services received at the CICP provider facility
  - Exception for homeless Clients and households with no income
- Department recommends that providers collect copayments prior to the Client receiving care except in emergent situations

Copayment Categories

- There are twelve different copayment categories:
  - Ambulatory Surgery
  - Inpatient Facility
  - Hospital Physician
  - Emergency Room
  - Emergency Transportation
  - Outpatient Hospital Services
  - Clinic Services
  - Specialty Outpatient Clinic
  - Outpatient Pharmacy
  - Laboratory Services
  - Basic Radiology and Imaging
  - High-Level Radiology and Imaging

Ambulatory Surgery

- Charges for all facility (non-physician) ambulatory surgery operative procedures received by a Client who is admitted and discharged from the hospital setting on the same day
- Can be combined with the Hospital Physician, Emergency Transportation, and/or Outpatient Pharmacy copayments

Inpatient Facility

- Charges for all facility (non-physician) services provided in a hospital setting during a continuous stay of 24 hours or more
- Can be combined with the Hospital Physician, Emergency Transportation, and/or Outpatient Pharmacy copayments

Hospital Physician

- Charges for services provided directly by a physician in the hospital setting
  - Physicians must either be employed directly by the hospital or have a contract with the hospital in which they agree to provide services to CICP Clients at the discount for the Hospital Physician copayment to be charged
- Can be combined with the Inpatient, Ambulatory Surgery, Emergency Room, or certain High-Level Radiology and Imaging copayments

Emergency Room

- Charges for all facility (non-physician) services received by a Client while receiving emergency or urgent care in the hospital setting for a continuous stay less than 24 hours
- Can be combined with the Hospital Physician, Emergency Transportation, and/or Outpatient Pharmacy copayments

Emergency Transportation

- Charges for transportation provided by an ambulance
  - Ambulance providers must either be owned by the hospital or have a contract with the hospital in which they agree to provide emergency transportation services to CICP clients at the discounted for the Emergency Transportation copayment to be charged
- Can be combined with the Ambulatory Surgery, Inpatient, Emergency Room, or the High-Level Radiology and Imaging copayments

Outpatient Hospital Service

- Charges for all facility and physician services received by a Client while receiving non-emergency or non-urgent care in the outpatient hospital setting
  - Includes primary and preventative medical care
  - Does not include radiology, laboratory, emergency room, or ambulatory surgery services provided in a hospital setting
- Can be combined with Outpatient Pharmacy, Laboratory, and/or Basic Radiology and Imaging copayments

Clinic Services

- Charges for all facility and physician services received by a Client while receiving care in the outpatient clinic setting
  - Includes primary and preventative medical care
  - Does not include radiology or laboratory services performed at the clinic
- Can be combined with Outpatient Pharmacy, Laboratory, and/or Basic Radiology and Imaging copayments

Specialty Outpatient

- Charges for all facility and physician services received by a Client while receiving care in the specialty outpatient setting
  - Can be provided in standalone clinics and outpatient hospital settings
  - Includes distinctive medical care (i.e. oncology, orthopedics, hematology, pulmonary) that is not normally available as primary or preventative care
  - Does not include radiology, laboratory, emergency room, or ambulatory surgery services provided in a hospital setting

Specialty Outpatient (cont.)

- Can be combined with the Outpatient Pharmacy and/or Laboratory copayments
- May be combined with the Basic Radiology copayment in certain situations:
  - If the Basic Radiology is provided in the clinic setting, can be combined
  - In the situation where a clinic sends a Client to the hospital for a basic radiology and imaging service, the hospital may only charge the basic radiology and imaging copay UNLESS they also explain the results to the Client, in which case the hospital would also be able to charge the client the Specialty Outpatient copay.

Outpatient Pharmacy

- Charges for prescription drugs received by a Client at the clinic or hospital's pharmacy as an outpatient service
- Can be combined with any other copayment

Laboratory Service

- Charges for laboratory test services received by a Client while receiving care in the outpatient hospital or clinic setting
- Can be combined with the Outpatient Hospital, Clinic, Specialty Outpatient, or High-Level Radiology and Imaging copayments

Basic Radiology and Imaging

- Charges for radiology and imaging services received by a Client while receiving care in the Outpatient Hospital or Clinic setting
- Can be combined with the Outpatient Hospital, Clinic, or High-Level Radiology and Imaging copayments
- May also be combined with the Specialty Outpatient if the service meets the requirements listed for that setting

High-Level Radiology and Imaging

- Charges for Clients receiving:
  - Magnetic Resonance Imaging (MRI)
  - Computed Tomography (CT)
  - Positron Emission Tomography (PET)
  - Nuclear Medicine services
  - Sleep Study
  - Catheterization Laboratory (cath lab)
- This copayment already includes the outpatient facility charge (i.e. Emergency Room, Specialty Outpatient Clinic)

High-Level Radiology and Imaging (cont.)

- Can be combined with the Emergency Transportation, Outpatient Pharmacy, Laboratory, and/or Basic Radiology and Imaging copayments.
- In the situation where a Clinic send a Client to the hospital for a High-Level service, hospital may only charge the High-Level copay UNLESS they also explain the results to the Client in which case they would also be able to charge the Hospital Physician copay.

Special Note: Observation Beds

- Clients who are seen in the hospital setting in an observation bed should be charged the Emergency Room copay if their stay is less than 24 hours and the Inpatient copay if their stay is 24 hours or longer

Charging Different Copays

- Clinic providers use their Federally approved SFS, which may include charges that are higher than the CICP standard copays
- Hospital providers can charge lower copays than the CICP standard, but may not charge higher copays
- Providers are also allowed to set up “packages” of services and only charge Clients one copay for multiple services or visits
  - i.e. One copay for a month’s worth of physical therapy visits

Different Copays

- If a Hospital decides to charge lower copays, the Department must be informed of the lower copays and the services they cover in order for the Hospital to report the lower copay in the annual data
  - If a provider does not inform the Department of the lower copays, they would be required to report the copays due as stated in the CICP copay table even if they did not collect the full amount

Question #1

- A Client is admitted to the hospital through the Emergency Room for a head injury that does not require surgery, and is released 16 hours later. Which facility charge is the correct charge for this client?
  - A. Emergency Room
  - B. Inpatient
  - C. Specialty Outpatient
  - D. Ambulatory Surgery

Answer #1

- A Client is admitted to the hospital through the Emergency Room for a head injury that does not require surgery, and is released 16 hours later. Which facility charge is the correct charge for this client?
  - A. Emergency Room
  - B. Inpatient
  - C. Specialty Outpatient
  - D. Ambulatory Surgery
- Emergency Room is the correct copayment since the Client did not stay in the hospital for 24 hours or longer and did not have surgery.

Question #2

- A Client is seen in the Emergency Room by a hospital physician who accepts CICP. The Client is then admitted to the hospital for three days and is seen by another hospital physician who also accepts CICP. What are the correct copays this Client should be charged?
  - A. Emergency Room and one Hospital Physician
  - B. Inpatient and two Hospital Physician
  - C. Inpatient and one Hospital Physician
  - D. Emergency Room, Inpatient, and two Hospital Physician

Answer #2

- What are the correct copays this Client should be charged?
  - A. Emergency Room and one Hospital Physician
  - B. Inpatient and two Hospital Physician
  - C. Inpatient and one Hospital Physician
  - D. Emergency Room, Inpatient, and two Hospital Physician
- A Client who is admitted through the Emergency Room is only responsible for the Inpatient copay. The Hospital Physician covers all physicians who treat the Client during their visit/admission.

Question #3

- A Client receives an x-ray in an Outpatient Clinic setting. Which of the radiology and imaging copayments should they be charged?
  - A. Basic Radiology and Imaging
  - B. High-Level Radiology and Imaging

Answer #3

- A Client receives an x-ray in an Outpatient Clinic setting. Which of the radiology and imaging copayments should they be charged?
  - A. Basic Radiology and Imaging
  - B. High-Level Radiology and Imaging
- X-rays are not included in the High-Level list of services, so the Basic copay is the correct choice

Question #4

- A Client with a rating of 197 goes to a clinic for their annual check-up and has a lab performed during the visit. What is the correct total copay charge for this visit?
  - A. $30
  - B. $35
  - C. $65

Service	186-200% Copay
Clinic Services	$35
Laboratory	$30

Answer #4

- A Client with a rating of 197 goes to a clinic for their annual check-up and has a lab performed during the visit. What is the correct total copay charge for this visit?
  - A. $30
  - B. $35
  - C. $65

Service	186-200% Copay
Clinic Services	$35
Laboratory	$30

- Since this is a Clinic setting, the Laboratory copay is allowed to be charged, so the correct answer would be $65.

Question #5

- Client goes to the Emergency Room and receives an MRI, a lab, and sees a CICP covered Hospital Physician. Which combination of copays is correct?
  - A. Emergency Room, Laboratory, and Physician
  - B. High-Level and Physician
  - C. High-Level, Emergency Room, and Physician

Answer #5

- Client goes to the Emergency Room and receives an MRI, a lab, and sees a CICP covered Hospital Physician. Which combination of copays is correct?
  - A. Emergency Room, Laboratory, and Physician
  - B. High-Level and Physician
  - C. High-Level, Emergency Room, and Physician
- Since MRIs are listed under the High-Level copay, the High-Level copay would be charged, which already includes the Emergency Room copay. Labs are not allowed to be charged in addition to the Emergency Room copay, so they are also not included.

Question #6

- If a Client has primary insurance and the amount remaining after insurance has paid is less than the normal CICP copay, what should the Client be charged?
  - A. $0
  - B. The normal CICP copay
  - C. The remaining charges

Answer #6

- If a Client has primary insurance and the amount remaining after insurance has paid is less than the normal CICP copay, what should the Client be charged?
  - A. $0
  - B. The normal CICP copay
  - C. The remaining charges
- Clients should be charged the lesser of the CICP copay, their insurance copay, or the remaining charges

Question #7

- If a client is hospitalized for multiple days, are they charged one Inpatient copay or a copay for each day they are hospitalized?
  - A. One Inpatient copay
  - B. One Inpatient copay for each day

Answer #7

- If a client is hospitalized for multiple days, are they charged one Inpatient copay or a copay for each day they are hospitalized?
  - A. One Inpatient copay
  - B. One Inpatient copay for each day
- The Inpatient copay covers the Client's entire stay in the hospital

Question #8

- Which copay should be charged for physical therapy visits?
  - A. Clinic
  - B. Outpatient Hospital
  - C. Specialty Outpatient

Answer #8

- Which copay should be charged for physical therapy visits?
  - A. Clinic
  - B. Outpatient Hospital
  - C. Specialty Outpatient
- Physical therapy sessions are outside of normal primary and preventative care, so the Specialty Outpatient copay is the most appropriate choice

Questions?

2020-21 Training

- Seven trainings available this year:
  - Income Calculation – Monday June 15 1:00 to 3:00 and Monday June 22 9:00 to 11:00
  - Application Policies – Tuesday June 16 1:00 to 3:00 and Thursday June 18 1:00 to 3:00
  - Copayments – Wednesday June 17 9:00 to 11:00 and Tuesday June 23 1:00 to 3:00
  - Question and Answer – Thursday June 25 1:00 to 3:00
- Try to have someone from your facility/facilities attend at least one session of each training
  - Attend the Q&A session!

Helpful Links

- Provider Information: https://www.colorado.gov/hcpf/cicp
  - Training sign up links and materials
  - Provider Manual
  - Current Client applications
- COVID FAQs: https://www.colorado.gov/hcpf/covid-19-provider-information#CICP
- CICP Email: hcpf_CICPCorrespondence@state.co.us

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Thank you!