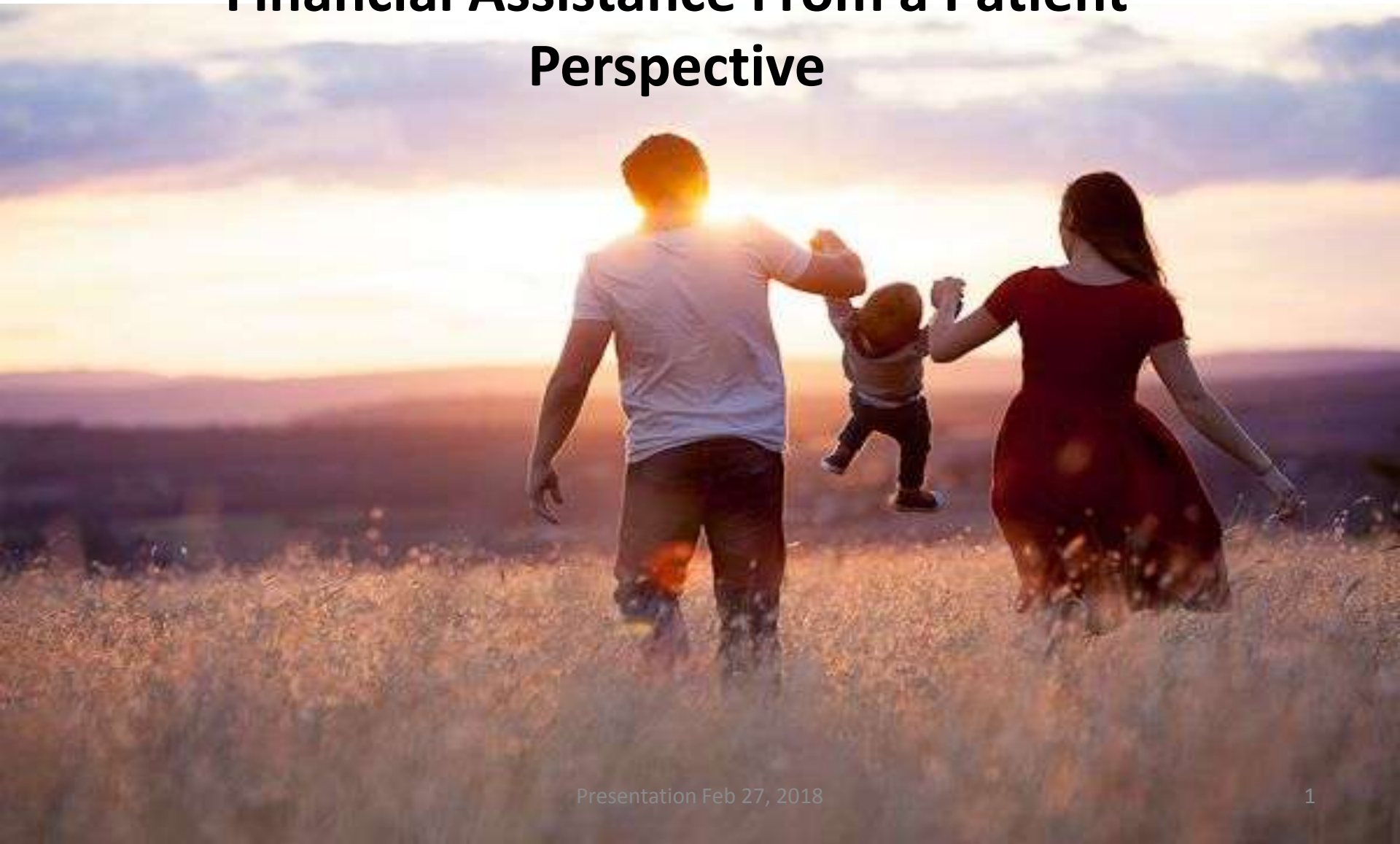
Financial Assistance From a Patient Perspective



The Affordable Care Act

The Affordable Care (federal health reform law) is a set of health insurance reforms that started in 2010.

Changes Include

- Coverage for pre-existing conditions
- No more lifetime limits on coverage
- The right to appeal health plan decisions
- Small business tax credits
- No more yearly limits on coverage
- Medicaid expansion 0%-133% FPL
- People who do not have health coverage have to pay a fee. (Note 2018 is still unknown)

History

Montezuma County	Colorado
Population: 26,693	Population: 5,555,653
Uninsured: 10.2%	Uninsured: 8.2%
Medicaid: 35.6%	Medicaid: 23.9%
Median Income: $42,975	Median Income: $63,945

Of the Coloradans Who Had Problems Paying Medical Bills ...

2013		2017
69.2%	Saved less or took funds out of savings	67.6%
42.6%	Took on credit card debt	46.2%
42.8%	Were unable to pay for necessities like food, heat or rent	37.2%
28.3%	Added hours or took another job	30.5%
17.2%	Took out a loan	15.7%
11.1%	Declared bankruptcy	5.4%

Medicare

2018 costs at a glance	
Part A premium	Most people don't pay a monthly premium for Part A (sometimes called "premium-free Part A"). If you buy Part A, you'll pay up to $422 each month. If you paid Medicare taxes for less than 30 quarters, the standard Part A premium is $422. If you paid Medicare taxes for 30-39 quarters, the standard Part A premium is $232.
Part A hospital inpatient deductible and coinsurance	You pay: • $1,340 deductible for each benefit period • Days 1-60: $0 coinsurance for each benefit period • Days 61-90: $335 coinsurance per day of each benefit period • Days 91 and beyond: $670 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) • Beyond lifetime reserve days: all costs
Part B premium	The standard Part B premium amount is $134 (or higher depending on your income). However, some people who get Social Security benefits will pay less than this amount ($130 on average).
Part B deductible and coinsurance	$183 per year. After your deductible is met, you typically pay 20% of the Medicare-approved amount for most doctor services (including most doctor services while you're a hospital inpatient), outpatient therapy, and durable medical equipment.
Part C premium	The Part C monthly premium varies by plan. Compare costs for specific Part C plans.
Part D premium	The Part D monthly premium varies by plan (higher-income consumers may pay more). Compare costs for specific Part D plans.

Medicare

- Medicare Part A covers Inpatient only

- Medicare Part B covers Outpatient services and Doctors visits including Emergency Room, SDS and Observation

- Medicare Part C combines part A-B and supplemental and is bought by the supplemental insurance company

- Medicare D prescriptions

Income Guidelines

FEDERAL POVERTY GUIDELINES*					
Household Size	Base FBL	Plan 1	Plan 2	Plan 3	Plan 4
CIRCLE ONE BELOW	100%	0%-250%	251%-300%	301%-350%	351%-400%
1	$12,140	$30,350	$36,420	$42,490	$48,560
2	$16,460	$41,150	$49,380	$57,610	$65,840
3	$20,780	$51,950	$62,340	$72,730	$83,120
4	$25,100	$62,750	$75,300	$87,850	$100,400
5	$29,420	$73,550	$88,260	$102,970	$117,680
6	$33,740	$84,350	$101,220	$118,090	$134,960
7	$38,060	$95,150	$114,180	$133,210	$152,240
8	$42,380	$105,950	$127,140	$148,330	$169,520
For families/households with more than 8 per add $4,320 for each additional person					
*Updated with the Department of Health and Human Services guidelines. Normally posted late January every year.					


Medicaid

Medicaid in the State of Colorado

Program name
MAGI (Modified Gross Income):
- Children
- Adults
- Pregnant
- Parent/Caretaker

Medicare Savings:
- QMB (Qualified Medicare Beneficiary)
- SLMB (Special Low-Income Medicare Beneficiary)
- QI-1 (Medicare Qualifying Individual-1)
- QDWI(Qualified Disabled Working Individuals)

Emergency Medicaid
Needy Newborn
Transitional Medicaid
CHP+: (Child Health Plan Plus)
- Children
- Prenatal
- Newborn

PROGRAM NAME	POPULATION SERVED	INCOME & RESOURCES	DISABILITY, LEVEL OF CARE and OTHER REQUIREMENTS	BENEFITS
MEDICARE SAVINGS PROGRAM				
QMB **Qualified Medicare Beneficiary**	Individuals eligible for Medicare May be eligible for other categories of Medicaid (Dual Eligible).	Resource limits are to be met during the duration of Medicaid eligibility.	▪ No disability or level of care requirements	▪ Payment of Medicare Part B premium, co-insurance, and deductibles
SLMB **Special Low-Income Medicare Beneficiary**	Individuals eligible for Medicare Part A	Resource limits are to be met during the duration of Medicaid eligibility.	▪ No disability or level of care requirements	▪ Payment of Medicare Part B premium
QI–1 **Medicare Qualifying Individual–1**	Individuals eligible for Medicare	Resource limits are to be met during the duration of Medicaid eligibility.	▪ No disability or level of care requirements	▪ Payment of Medicare Part B premium
QDWI **Qualified Disabled Working Individuals**	Individuals who lose Social Security Disability Insurance (SSDI) benefits due to excess earned income	Resource limits are to be met during the duration of Medicaid eligibility.	▪ No disability or level of care requirements	▪ Payment of Medicare Part A premium

PROGRAM NAME	POPULATION SERVED	INCOME & RESOURCES	DISABILITY, LEVEL OF CARE and OTHER REQUIREMENTS	BENEFITS
LOW INCOME SUBSIDY				
LIS **Low-Income Subsidy**	Individuals eligible for Medicare	Resource limits are to be met during the duration of Medicaid eligibility.	▪ Please refer individuals to SSA to apply for LIS ▪ Eligibility Sites can make determinations within CBMS for LIS IF the member "insists" on a county determination ▪ Medicare eligible individuals do not need to apply for LIS if they are active Medicaid or MSP. These individuals are automatically deemed eligible for LIS. Monthly Data Extracts are sent to SSA for these individuals.	▪ Payment of Medicare Part D premium and reduced co-pays

PROGRAM NAME	POPULATION SERVED	INCOME & RESOURCES	DISABILITY, LEVEL OF CARE and OTHER REQUIREMENTS	BENEFITS
EMERGENCY MEDICAL ASSISTANCE				
Emergency Medicaid **(All Medicaid Categories)**	Medical Assistance for non-qualified aliens (undocumented aliens), and have a life or limb medical condition. An emergency medical condition is a medical condition (including labor and delivery) which manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the patient's health in serious jeopardy, serious impairment of bodily function, or serious dysfunction of any bodily organ or part. Eligibility for emergency medical assistance ends after the emergency service has been provided.	Income and resource limits follow the Medical Assistance category limits under which the individual is eligible.	Member must first be determined to be eligible for a category of Medicaid. A physician shall make a written statement certifying the presence of a medical emergency condition when services are provided and shall indicate that services were for a medical emergency on the claim form. The non-qualified immigrant must have an emergency medical condition and receive emergency medical services in order to be eligible for emergency medical assistance.	▪ Emergency Medical Services only- Includes labor and delivery ▪ Includes limited dental services as needed for emergency treatment of the oral cavity. Coverage is limited to care and services that are necessary to treat immediate emergency medical conditions. Coverage does not include prenatal care or follow-up care, such as postpartum care.

PROGRAM NAME	POPULATION SERVED	INCOME & RESOURCES	DISABILITY, LEVEL OF CARE and OTHER REQUIREMENTS	BENEFITS
Modified Adjusted Gross Income (MAGI) and Child Health Plan Plus (CHP+)				
MAGI Children	Children under the age of 19	5% income disregard No resource test	None	▪ Acute Care Benefits ▪ Durable Medical Equipment ▪ Non-Emergency Medical Transportation ▪ Behavioral Health Services ▪ Emergency Services ▪ Preventative and wellness services in accordance with the Affordable Care Act (ACA) ▪ Prescription Services ▪ Limited Physical Therapy, Occupational Therapy, and Speech Pathology ▪ Podiatry Services ▪ Optometry Services ▪ Private Duty Nursing ▪ Hospice Care ▪ Dental Services ▪ + Early Periodic Screening, Diagnosis and Treatment (EPSDT)

MAGI Parent/Caretaker	Parents or Caretaker Relatives (within the fifth degree of kinship) of a Medicaid eligible child	5% income disregard No resource test	None	▪ Acute Care Benefits ▪ Durable Medical Equipment ▪ Non-Emergency Medical Transportation ▪ Behavioral Health Services ▪ Emergency Services ▪ Prescription Services ▪ Limited Physical Therapy, Occupational Therapy, and Speech Pathology ▪ Podiatry Services ▪ Optometry Services ▪ Private Duty Nursing ▪ Hospice Care ▪ Preventative and wellness services in accordance with the Affordable Care Act (ACA) ▪ Dental Services
MAGI Adult	Adults age 19 through the end of the month that the individual turns 65, who do not receive or who are ineligible for Medicare.	5% income disregard No resource test	None	▪ Acute Care Benefits ▪ Durable Medical Equipment ▪ Non-Emergency Medical Transportation ▪ Behavioral Health Services ▪ Emergency Services ▪ Prescription Services ▪ Limited Physical Therapy, Occupational Therapy, and Speech Pathology ▪ Podiatry Services ▪ Optometry Services ▪ Private Duty Nursing ▪ Hospice Care ▪ Preventative and wellness services in accordance with the Affordable Care Act (ACA) ▪ Dental Services

MAGI Pregnant	Pregnant women age 19 and over, including women who are 60 days post-partum.	5% income disregard No resource test	None	▪ Acute Care Benefits ▪ Durable Medical Equipment ▪ Non-Emergency Medical Transportation ▪ Behavioral Health Services ▪ Emergency Services ▪ Prescription Services ▪ Limited Physical Therapy, Occupational Therapy, and Speech Pathology ▪ Podiatry Services ▪ Optometry Services ▪ Private Duty Nursing ▪ Hospice Care ▪ Preventative and wellness services in accordance with the Affordable Care Act (ACA) ▪ Dental Services
Needy Newborn	Babies age 0-12 months who were born to a mother on Medicaid	None	None	▪ Acute Care Benefits ▪ Durable Medical Equipment ▪ Non-Emergency Medical Transportation ▪ Behavioral Health Services ▪ Emergency Services ▪ Prescription Services ▪ Limited Physical Therapy, Occupational Therapy, and Speech Pathology ▪ Podiatry Services ▪ Optometry Services ▪ Private Duty Nursing ▪ Hospice Care ▪ + Early Periodic Screening, Diagnosis and Treatment (EPSDT) ▪ Preventative and wellness services in accordance with the Affordable Care Act (ACA) ▪ Dental Services

Transitional Medicaid	Continuing Medicaid coverage for 12 months, to families who are ineligible for MAGI Medicaid due to increased earnings or new work income.	Guaranteed 12 months - no income limit. No resource test.	Eligibility depends solely on MAGI Medicaid History. A member must have received MAGI Children or MAGI Parent/Caretaker Relative Medical Assistance 3 out of the 6 months prior to the earned income increase.	▪ Acute Care Benefits ▪ Durable Medical Equipment ▪ Non-Emergency Medical Transportation ▪ Behavioral Health Services ▪ Emergency Services ▪ Prescription Services ▪ Limited Physical Therapy, Occupational Therapy, and Speech Pathology ▪ Podiatry Services ▪ Optometry Services ▪ Private Duty Nursing ▪ Hospice Care ▪ + Early Periodic Screening, Diagnosis and Treatment (EPSDT) for those under 21 ▪ Preventative and wellness services in accordance with the Affordable Care Act (ACA) ▪ Dental Services
4 Month Extended	Continuing Medicaid coverage for 4 months, to families who are ineligible for MAGI Medicaid due to receipt of alimony/maintenance.	Guaranteed 4 months – no income limit No resource test	A member must lose MAGI Children or MAGI Parent/Caretaker Relative Medical Assistance due to the receipt of alimony/maintenance to receive 4 Month Extended.	▪ Acute Care Benefits ▪ Durable Medical Equipment ▪ Non-Emergency Medical Transportation ▪ Behavioral Health Services ▪ Emergency Services ▪ Prescription Services ▪ Limited Physical Therapy, Occupational Therapy, and Speech Pathology ▪ Podiatry Services ▪ Optometry Services ▪ Private Duty Nursing ▪ Hospice Care ▪ + Early Periodic Screening, Diagnosis and Treatment (EPSDT) for those under 21 ▪ Preventative and wellness services in accordance with the Affordable Care Act (ACA) ▪ Dental Services

CHP+ Children	Low income children (18 years of age and younger) who are ineligible for MAGI Children due to income	5% income disregard No resource test	None	Low-cost health insurance. Coverage includes: • Inpatient and outpatient hospital services • Physician services • Prescription drugs • CHP+ Dental for children • Behavioral health care
CHP+ Prenatal	Pregnant women (19 years of age and older) who are ineligible for MAGI Pregnant due to income	5% income disregard No resource test	None	Low-cost health insurance. Coverage includes: • Inpatient and outpatient hospital services • Physician services • Prescription drugs • CHP+ Dental for children • Behavioral health care
CHP+ Newborn	Babies age 0-12 months who were born to a mother on CHP+	None	None	Low-cost health insurance. Coverage includes: • Inpatient and outpatient hospital services • Physician services • Prescription drugs • CHP+ Dental for children • Behavioral health care

Medicaid Income Guidelines:

COLORADO
Department of Health Care Policy & Financing

MAGI MEDICAID
Monthly Maximum Income Guidelines[1]
Effective April 1, 2017

Family Size	Parents & Caretaker Relatives 68% Poverty Level	Adults (Ages 19-65) 133% Poverty Level	Children (Ages 0-18) 142% Poverty Level	Pregnant Women 195% Poverty Level
1	684	1,337	1,428	1,960
2	921	1,800	1,922	2,639
3	1,158	2,264	2,417	3,319
4	1,394	2,727	2,911	3,998
5	1,631	3,190	3,406	4,677
6	1,868	3,654	3,901	5,356
7	2,105	4,117	4,395	6,036
8	2,342	4,580	4,890	6,715
9	2,579	5,043	5,385	7,394
10	2,816	5,507	5,879	8,073

[1] Co-payments may apply; no co-pays for American Indians, Alaska Natives, or for a pregnant woman and her household.

Our mission is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.


CICP

What Is CICP (Colorado Indigent Care Program)?

- CICP is a discount program not an insurance
- Administered by participating providers
- Funded with federal and state dollars
- Cannot be eligible for Medicaid or CHP+
- Income and resources combined at or below 250% Federal Poverty Level
- Can have Medicare or private insurance
- Can back date 90 days from date of service
- Will have a copay according to a rating scale
- Renew annually and when circumstances change

SOUTHWEST HEALTH SYSTEM

COLORADO INDIGENT CARE PROGRAM (CICP)

What is the Colorado Indigent Care Program (CICP)?
The CICP provides discounted health care services to eligible persons who receive medical care from participating providers. CICP is funded with federal and state dollars to partially compensate participating providers for costs associated with providing health care services. The Colorado Department of Health Care Policy and Financing (HCPF) administers the CICP.

This is not a health insurance program. Services are restricted to participating hospitals and clinics throughout the state and medical services vary by participating health care provider. The responsible physician or health care provider determines what services will be covered. These services may include, but are not limited to emergency care, inpatient and outpatient care and prescription drugs.

Eligibility requirements
Local hospitals and clinics enroll families on CICP. To be eligible for discounted services under the program, applicants must meet residency, income and asset requirements. A resident is anyone who resides in Colorado legally or is a migrant worker and legal immigrant, who has limited financial resources, is uninsured or underinsured, and is not eligible for benefits under the Health First Colorado (Medicaid) Program or the Children's Basic Health Plan (CHP+).

To qualify
Applicants must have income and resources combined at or below 250% of the Federal Poverty Level (FPL), **and cannot be eligible for Medicaid or CHP+**. There are no age limitations for CICP eligibility. Applicants can have Medicare and any other commercial health insurance policy, but these policies **must** be exhausted before CICP reimburses the health care provider.

Applications
The application must be completed by the participating health care provider. The applicant or responsible party must sign the application within 90 days of the date of service. If the applicant or responsible party is unable to sign the application or has died, a signature should be provided by a spouse, relative or guardian or provider. Without a completed, signed application, discounted services cannot be provided to the applicant and no appeal rights exist. Applicants have the right to appeal their application within 15 days of completing the application. Appeals must be received in **writing** and delivered to the provider where the application was completed.

Rating
Applicants will be assigned a "rate" based on their total income and resources. The rating process takes a "snapshot" of the applicant's financial resource as of the date the rating takes place. Ratings cover services that were received up to 90 days prior to their application. The results of the rating will determine the client's copayments for the year. If a client moves or changes providers it is the client's responsibility to tell the eligibility technician at the new provider of their CICP rating.

Example of CICP Maximum Income Guidelines		
Family Size	Annual Income	Monthly Income
1	$30,150	$2,512
2	$40,600	$3,383
3	$51,050	$4,254
4	$61,500	$5,125
5	$71,950	$5,995
6	$82,400	$6,866

Changes to the rating or application may occur when:
- ✓ The year has expired;
- ✓ Family income has changed significantly;
- ✓ The number of dependents has changed; **or**
- ✓ Information provided was not accurate.

Copayment cap. Clients pay no more than 10% of their income from the date of the application. Clients are responsible for keeping track of the copayments and informing providers once the family has reached the 10% copayment cap.

Do applicants have to apply for Medicaid or CHP+ before they can be eligible for CICP?
If, based on family income and resources, applicants "appear" to be categorically eligible for Medicaid or CHP+, they must apply for Medicaid or CHP+ before they can apply for CICP. A denial letter from Medicaid or CHP+ must be received before the CICP application can be completed.

Can individuals who have Medicare or other health insurance apply for CICP?
Yes, they can still apply for CICP. However, the clinic or hospital must bill those clients' commercial health insurance policy first for all medical expenses incurred.

Where can I apply for this program?
You need to apply at a CICP contracted provider. A list of participating providers can be found at the Department of Health Care Policy & Financing's web site at Colorado.gov/hcpf. Click clients & applicants, the CICP link located at top menu bar or call Customer Service at 303-866-3513 or 1-800-221-3943.

Checklist for Eligibility
(More information may be requested.)

- ✓ State of Colorado driver's license or state identification card
- ✓ Proof of immigration status
- ✓ Copy of most recent paycheck stubs (to equal one month)
- ✓ Social Security Disability Insurance (SSDI)
- ✓ Supplemental Security Income (SSI) award letter
- ✓ Payments from pension plans
- ✓ Payments from Aid to the Needy and Disabled (AND) or Old Age Pension (OAP)
- ✓ Proof of **all** income for the household
- ✓ Proof of **all** assets
- ✓ A copy of Medicare or health insurance card
- ✓ Documentation of prior medical, physician, pharmacy expenses (previous year)

Local CICP Providers

Southwest Memorial Hospital
Southwest Memorial Primary Care
Southwest Memorial Walk-In Clinic
Southwest Memorial Specialty Care
Mancos Valley Health Center
Dolores Health Center

Make an appointment to apply for CICP by contacting:

Rhonda Hatfield
Patient Financial Coordinator
Phone: (970) 564-2131
Fax: (970) 564-2159
E-mail: rhatfield@swhealth.org

Felice Vigil
Patient Financial Counselor
Phone: (970) 564-2132
Fax: (970) 564-2159
E-mail: fvigil@swhealth.org


FAP

FAP (Financial Assistance Program)

- FAP is specific to Southwest Health System
- FAP is a program not an insurance
- Can be used with other insurance and CICP including Medicare
- Is a charitable program sliding scale based on Federal Poverty Level up to 400%
- Can backdate for up to 240 days from the date of service
- May have a copay depending on the plan
- Renew annually and when circumstances change
- 4 Tiers :

	0%-250%	251%-300%	301%-350%	351%-400%
PLAN	Plan 1 Patient Copay	Plan 2 Patient Copay	Plan 3 Patient Copay	Plan 4 Patient Copay
Clinic Services	$ 0.00	$ 15.00	$ 20.00	$ 25.00
Hospital Services	$ 0.00	20% of Patient Statement	30% of Patient Statement	50% of Patient Statement
Discount	100%	80%	70%	50%

Other Options

25% Discount Self Pay Only:
A 25% discount will be given to self pay accounts, if no insurance has been billed, and if the account is paid in full within 30 days from date of the first statement to patient/guarantor.

Payment Plan:
A payment plan can be set up through the Patient Financial Services Office (PFS/billing office) or our Early Out Sourcing company. It is the responsibility of the patient to contact PFS to add other accounts to the initial payment plan if there are more than one account.

Payroll deduction:
A payroll deduction can be set up for Employees and their families. Each account must be set up separately and it is the responsibility of the Employee to contact PFS to sign a payroll deduction authorization.

How can we help you?

All patients that are uninsured (self pay) or underinsured (large deductibles, Medicare), or have outstanding balances they are unable to pay should be encouraged to speak with a Financial Counselor as soon as possible.

Financial assistance resources can be found at http://swhealth.org/financialassistance/

There are time constraints