REPORT OF

THE

STATE AUDITOR

Colorado Indigent Care Program
Department of Health Care Policy and Financing

Performance Audit
February 2002

LEGISLATIVE AUDIT COMMITTEE
2002 MEMBERS

Senator Jack Taylor
Chairman

Senator Ron Tupa
Vice-Chairman

Senator Norma Anderson
Representative Fran Coleman
Representative Glenn Scott
Senator Stephanie Takis
Representative Val Vigil
Representative Tambor Williams

Office of the State Auditor Staff

Joanne Hill
State Auditor

Sally W. Symanski
Cindy P. Drake
Gregory A. Fugate
Illana Poley
Legislative Auditors

STATE OF COLORADO

JOANNE HILL, CPA
State Auditor

OFFICE OF THE STATE AUDITOR
(303) 866-2051
FAX(303)866-2060

Legislative Services Building
200 East 14th Avenue
Denver, Colorado 80203-2211

February 28, 2002

Members of the Legislative Audit Committee:

This report contains the results of the performance audit of the Colorado Indigent Care Program. The audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of state government. The report presents our findings, conclusions, and recommendations, and the responses of the Department of Health Care Policy and Financing.

TABLE OF CONTENTS

STATE OF COLORADO
OFFICE OF THE STATE AUDITOR **REPORT SUMMARY**

JOANNE HILL, CPA
State Auditor

Colorado Indigent Care Program
Department of Health Care Policy and Financing
Performance Audit - February 2002

Authority, Purpose, and Scope

This audit of the Colorado Indigent Care Program (CICP) was conducted under the authority of Section 2-3-103, C.R.S., which authorizes the Office of the State Auditor to conduct performance audits of all departments, institutions, and agencies of state government. The audit was performed in accordance with generally accepted auditing standards. The purpose of the audit was to review the Department of Health Care Policy and Financing's (HCPF) controls over the administration of CICP and reimbursements paid to participating providers for services to CICP-eligible individuals. We also examined policy issues related to provider reimbursement under CICP and the program's relationship with the Medicaid program. We interviewed HCPF staff, reviewed documentation, and analyzed information. In addition, we tested a sample of CICP charges submitted by providers and conducted a survey of CICP providers. Audit work was performed between July 2001 and February 2002.

We would like to express our appreciation for the assistance and cooperation extended by management and staff at the Department and at the Denver Health Medical Center and the University of Colorado Hospital.

Overview

CICP was authorized by House Bill 83-1129, the "Reform Act for the Provision of Health Care for the Indigent." Prior to this, the State had procedures to partially reimburse providers for care furnished to the medically indigent; however, the program was not formally recognized in statutes. CICP is not an entitlement; therefore, the State is not legally obligated to serve all who meet the program's eligibility requirements. CICP is a financing mechanism through which the State reimburses participating providers for a portion of costs incurred in treating individuals who are eligible for CICP. In turn, providers must adhere to state-established limits for amounts charged to CICP individuals. To receive CICP services, individuals must be state residents not eligible for Medicaid whose combined net income and assets do not exceed 185 percent of the federal poverty level ($32,653 for a family of four as of April 2001) and are otherwise uninsured or underinsured. Copayments are based on a sliding scale and range from zero to $535. A family's annual payments are capped at 10 percent of its net income and assets.

CICP is not an insurance plan under state law because it does not provide individuals with a policy that defines a list of benefits to which they are entitled. Statutes limit the program's expenditures to available appropriations and the individual provider's physical, financial, and staff resources. In terms of services, statutes only require that providers manage CICP funds to ensure the following priorities are met:

- Emergency care for the entire year.
- Additional care for conditions the Department determines to be the most serious threat to a medically indigent person's health.
- Other medical care.

In Fiscal Year 2001 the program partially funded services to about 160,100 individuals and made payments to 66 providers totaling about $131.9 million. HCPF is responsible for establishing CICP policies and procedures, proposing rules to the Medical Services Board as needed, contracting with providers, compiling CICP charges, allocating funds among providers, and informing providers of program requirements. Providers are responsible for determining CICP eligibility, submitting data on CICP services, and generally meeting program requirements.

Under statutes, CICP providers must be a facility such as a hospital, birth center, or community health clinic licensed by the Department of Public Health and Environment. Statutes designate Denver Health Medical Center (Denver Health) as the primary provider of indigent care in the City and County of Denver and the University of Colorado Hospital (University Hospital) as the primary provider for the Denver metropolitan area. Providers annually report uncompensated charges for services furnished to CICP individuals. From charges, HCPF derives the estimated cost of these services for each provider. These estimated costs are the basis upon which providers are reimbursed; thus, the term "reimbursement rate" as used in this report refers to the provider's reimbursement payments relative to the provider's estimated CICP costs. HCPF uses a prospective payment method in which the estimated CICP costs as derived from CICP charges from two years prior are used as the basis for calculating payments in the current fiscal year. Additionally, some CICP hospitals receive other payments under CICP, as described below.

Reassess Variations in Provider Reimbursement Rates

In Fiscal Year 2001, total CICP provider payments of $131.9 million were funded by $115.0 million in federal Medicaid funds (87 percent) and $16.9 million in state general funds (13 percent). Under CICP, providers are placed into one of three categories (Component 1A, Outstate hospitals, and Outstate clinics), depending on the type of provider and the provider's Medicaid utilization rate. We found that providers receive widely varying reimbursement rates, largely on the basis of the category in which they are placed. As a result, CICP payments to providers are not necessarily linked to the volume of CICP services rendered.

Currently all hospitals in the Component 1A category are paid significantly higher reimbursement rates, which are based on their higher Medicaid utilization, than are Outstate providers. For example, in Fiscal Year 2001 one Outstate hospital had CICP costs of about $3.6 million and received reimbursement of $977,500 (27 percent of CICP costs). On the other hand, a Component 1A hospital had CICP costs of about $3.8 million and received reimbursement of $3.6 million (95 percent of CICP costs). This Component 1A provider was also paid over $1 million in bad debt payments. The three categories, the types of payments providers in each category receive, and their reimbursement rates are as follows:

- *Component 1A hospitals*. These hospitals must have a higher Medicaid inpatient utilization rate than average (i.e., at least one standard deviation above the mean rate for all Medicaid hospitals in the State). Payments are based on CICP estimated costs, and are made with federal Disproportionate Share Hospital program (DSH) funds under the Medicaid program. DSH provisions allow additional federal payments to Medicaid hospitals serving a disproportionate number of Medicaid and other low-income patients.

  All Component 1A hospitals may receive additional DSH payments under CICP as reimbursement for part of their bad debt incurred from all non-paying patients. Further, Denver Health and University Hospital receive other Medicaid funds under the Major Teaching Hospital (MTH) program, which directs additional federal payments to qualifying teaching hospitals in the State. Including Component 1A, bad debt, and MTH payments, in Fiscal Year 2001 Component 1A hospitals received the following amounts and reimbursement rates: Denver Health, $65 million (78.8 percent of CICP costs); University Hospital, $36 million (81.7 percent of CICP costs); and the seven private hospitals, $11 million in total (138.4 percent of CICP costs on average). Denver Health and University Hospital receive lower rates of reimbursement than the seven private hospitals in Component 1A because these two public hospitals do not receive any state general funds as part of their payments from the State. Instead, Denver Health and University Hospital "certify" their CICP costs; these certified expenditures are used by the State as the basis for drawing federal funds instead of spending state general funds.

- *Outstate hospitals*. Hospitals must have an inpatient Medicaid utilization rate of at least 1 percent but less than one standard deviation above the mean. Payments are based on estimated CICP costs and are made with equal amounts of federal DSH funds and state general funds. Certification of public expenditures is not used, although some hospitals are publically owned. In Fiscal Year 2001 these 40 providers received a total of $15 million and were reimbursed for 27 percent of their estimated CICP costs. These hospitals do not receive bad debt or MTH payments.

- *Outstate clinics*. Clinics do not have to meet a specific Medicaid utilization rate to participate in CICP. Payments are based on estimated CICP costs. Clinics do not qualify for DSH payments; state general funds are used to fund all payments. In Fiscal Year 2001, 17 clinics were paid $4.9

million and were reimbursed for 27 percent of their estimated CICP costs. Clinics do not receive any other payments under CICP.

Reevaluate Statewide CICP Policies

We identified two areas in which state policy needs to be reevaluated.

Basis for determining CICP payments to providers. The State should reassess the basis on which payments are made to providers in order to ensure that payments are determined on an accurate and equitable basis. Our audit identified significant weaknesses in HCPF's controls over the reimbursement process and the accuracy and comparability of CICP charges submitted by providers. As a result, the Department is unable to ensure that payments to providers are accurate and equitable. Among other problems, we identified $5.1 million in overstated Fiscal Year 2002 payments in one category. Providers in each category are paid from one pool of funds; if one provider is overpaid, fewer funds are available to pay others in that category.

Our audit recommended that administrative oversight be improved if CICP charges are to continue as the primary basis for payments. Alternatively, the State could use another basis for determining providers' reimbursement under CICP. For example, payments could be linked to Medicaid utilization or some other measure of low-income services. The alternative would need to be based on information over which there are already adequate controls to ensure its accuracy and comparability. While such an alternative would not tie CICP payments directly to CICP services, it could provide an equitable basis for determining payments and simplify the administration of CICP because the Department would no longer need to collect data on CICP charges and ensure the accuracy and comparability of those charges.

Role of clinics. Additionally, CICP has evolved in several ways that are not entirely consistent with program statutes. First, the role of clinics in CICP should be clarified. Clinics have long been accepted as a critical component of CICP because they furnish primary care. However, clinics are not designed or intended to meet CICP statutory medical services priorities (e.g., provide emergency medical services for the entire year). Second, statutes state that providers are not to be funded at levels that exceed CICP costs. However, because of bad debt payments, in some instances Component 1A providers receive CICP payments that in total exceed their CICP costs. While we recognize that bad debt represents uncompensated costs and these payments are not calculated based on CICP costs, we question whether some providers should be reimbursed in excess of their CICP costs when others are being reimbursed at only 27 percent of CICP costs.

Ensure Accuracy of Provider Payments

We identified the following problems with HCPF's oversight of CICP and provider payments. We tested Fiscal Year 2000 CICP data, upon which Fiscal Year 2002 payments were calculated.

- The Department does not audit any of the charges submitted. We tested a sample of CICP charges and found that University Hospital was billing the State for charges disallowed under federal Medicare regulations. HCPF had overstated this provider's Fiscal Year 2002 reimbursement by about $2 million because of these charges.

- HCPF obtains only summary data, rather than detailed charges and adjustments, for services subcontracted by CICP providers. Denver Health and University were unable to substantiate $245,800 (0.2 percent) and $1,048,400 (1.3 percent), respectively, of their CICP charges for Fiscal Year 2000. Denver Health discovered it had erroneously submitted about $3 million in CICP charges when reviewing its data. University Physicians, Inc., a subcontractor for CICP services for University Hospital and for Children's Hospital, discovered it had mistakenly submitted almost $2.2 million in duplicate charges. These errors likely would have gone undetected, had we not made our request. These mistakes resulted in an overstatement in total for all three providers' Fiscal Year 2002 reimbursements of about $1.7 million.

- In addition to errors made by providers, the Department itself made errors in calculating University Hospital's Fiscal Year 2002 payment that resulted in a $1.4 million overstatement of this payment. In other instances, we found a lack of consistency and documentation that could have resulted in other errors' going undetected. We also noted that the methodology used to calculate reimbursements for Component 1A providers uses outdated and inaccurate information that affects the equity of payments for those providers.

Ensure Receipt and Review of Provider Audits

HCPF does not systematically review the annual CICP audits providers are required to submit. For Fiscal Year 1999, for which all audits should have been submitted, 14 audits (20.9 percent) were not on file. These providers were paid in total almost $2.6 million for that year. Two providers had no audits on file for the last three years, and five had no audits on file for two years. During our provider survey, one provider said it was not aware the program had an audit requirement. Also, for a sample of 25 audits for Fiscal Year 1999, 7 had sufficiently high error rates to require the submission of a corrective action plan; however, only 1 had done so. Finally, the testing requirements that auditors are directed to perform are not adequate to identify problems with CICP charges. This is confirmed by the problems we found during our testing.

Assess Duplicate Payments for CICP and Medicaid

CICP appears to have a significant overlap with the Medicaid program, and the Department lacks procedures to ensure these problems are adequately addressed. For CICP charges for services rendered in April 2000, we identified 1,622 individuals who were Medicaid-eligible at the time they received CICP services. We estimate that providers were paid about $554,800 for these CICP services. In almost half

of these cases, the individual had been determined Medicaid-eligible at least three months prior to April 2000. In the remaining cases, Medicaid eligibility may have been pending in April 2000 and providers may have subsequently reversed the CICP charges. However, HCPF has no effective way to determine whether such adjustments were made.

Finally, the Department needs to ensure that all CICP expenditures certified by public hospitals as public expenditures are an appropriate basis upon which to draw federal Medicaid funds.

The Department agreed with 16 of the 18 recommendations in the report and partially agreed with 2 recommendations. A summary of our recommendations and the Department's responses can be found in the Recommendation Locator.

RECOMMENDATION LOCATOR

All recommendations are addressed to the Department of Health Care Policy and Financing.

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
1	37	Present options for making provider payments under the Colorado Indigent Care Program by (a) developing alternatives to using CICP costs derived from CICP charges as the basis for provider reimbursements and (b) for alternatives that use CICP charges as the basis for reimbursement, investigating ways to link provider payments more directly to the volume of CICP services rendered by providers. The Department should furnish a report to the General Assembly on these options by December 1, 2002.	Agree	December 1, 2002
2	42	Seek legislative change to clarify the intent of and requirements for the Colorado Indigent Care Program including (a) the role of clinics in providing primary care in relation to requirements in statute establishing medical services priorities; (b) prohibitions against reimbursements that exceed CICP costs in cases where providers receive other payments, such as those for bad debt; and (c) statutory requirements that are obsolete or need to be reassessed.	Agree	2003 Session of the General Assembly
3	48	Follow up on the results of the data match performed by the Office of the State Auditor between the Colorado Indigent Care Program and the Medicaid program, and seek reimbursement as appropriate.	Partially Agree	July 1, 2002
4	49	Ensure that applicants for the Colorado Indigent Care Program are screened for Medicaid eligibility in all appropriate instances by training providers on Medicaid eligibility screening procedures.	Agree	July 1, 2002

RECOMMENDATION LOCATOR

All recommendations are addressed to the Department of Health Care Policy and Financing.

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
5	49	Ensure post-year-end retroactive adjustments are made to charges for the Colorado Indigent Care Program by developing and implementing procedures for providers to report these adjustments.	Agree	October 31, 2002
6	60	Reduce the projected Fiscal Year 2002 payment to University Hospital to reflect the provider's overbilling of the State for Medicare contractual adjustments of approximately $6.7 million, and work with the Centers for Medicare and Medicaid Services to determine additional actions the State should take with respect to prior years.	Agree	July 1, 2002
7	61	Ensure charges submitted for the Colorado Indigent Care Program are consistent with the program's intent and reported on the same basis for all providers by (a) developing formal policies regarding the basis for reported charges and treatment of adjustments and (b) performing periodic on-site testing of charges and related adjustments.	Agree	a. July 1, 2002 b. No implementation date provided by the Department.
8	64	Reduce the projected Fiscal Year 2002 payments for (a) Denver Health to reflect the provider's overbilling of the State for ambulance charges for the Colorado Indigent Care Program in the amount of $2,996,000 and (b) University Hospital and Children's Hospital for duplicate physician charges of $1,973,900 and $189,800 respectively. In addition, HCPF should consider the need for prior year adjustments based on charges from University Physicians, Inc.	Agree	July 1, 2002

RECOMMENDATION LOCATOR

All recommendations are addressed to the Department of Health Care Policy and Financing.

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
9	65	Ensure that charges and related adjustments submitted to the Colorado Indigent Care Program are appropriate by establishing policies and procedures that enforce contractual provisions requiring providers to maintain detailed data to substantiate all reported charges, including those for contractual services.	Agree	July 1, 2002
10	67	Correct the numbers for University Hospital in the CICP Fiscal Year 2000 annual report and make the necessary adjustments to Fiscal Year 2002 Component 1A reimbursements.	Agree	July 1, 2002
11	68	Develop and implement controls over provider data used in the Colorado Indigent Care Program reimbursement process by (a) establishing a formal review process for provider data in the annual report and (b) ensuring staff are cross-trained in reimbursement methodologies and review each other's work.	Agree	a. February 2002 b. No implementation date provided by the Department.
12	72	Develop and implement controls over the reimbursement process for the Colorado Indigent Care Program by (a) applying the reimbursement methodology consistently to all providers within each CICP provider category and documenting reasons for any exceptions; (b) obtaining audited information on which to base providers' cost-to-charge ratios; (c) in instances where audited information is not available, requiring that providers submit all necessary supporting documentation; (d) informing providers about all policies and procedures related to provider reimbursements.	Agree	October 31, 2002

RECOMMENDATION LOCATOR

All recommendations are addressed to the Department of Health Care Policy and Financing.

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
13	77	Consider revising the Component 1A prospective payment calculation method to be consistent with that used for the Outstate providers.	Agree	December 1, 2002
14	83	Improve controls over the certification process for the Colorado Indigent Care Program by (a) formally documenting annual comparisons of certified public expenditures by each provider to the provider's actual CICP write-off costs, (b) obtaining confirmation from the federal Centers for Medicare and Medicaid Services on whether shortfalls in certified expenditures under Component 1A may be offset by excess certifiable expenditures under a different amendment to the State Plan, (c) informing providers of the purpose of certification and that expenditures cannot be certified if they are reimbursed by other federal funds, and (d) requiring that providers include an assurance in quarterly certification letters stating that no federal funds were received as reimbursement for the certified expenditures, other than those through CICP.	Partially Agree	a. Not applicable b, c, d. July 1, 2002
15	87	Increase the effectiveness of the audit function for the Colorado Indigent Care Program by (a) assessing the Department's role in on-site audits for the program and performing audits on providers that represent the highest risk on a periodic basis, (b) considering the option of contracting with a public accounting firm to perform on-site audits of the program, and (c) revising the provider audit requirement to more appropriately reflect the level of risk represented by providers.	Agree	a, b. No implementation date provided by the Department. c. July 1, 2002

RECOMMENDATION LOCATOR

All recommendations are addressed to the Department of Health Care Policy and Financing.

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
16	91	Improve procedures for monitoring provider audits for the Colorado Indigent Care Program by (a) maintaining current data on the receipt and review of provider audits, (b) following up with providers in instances where audits have not been submitted on time, (c) requiring corrective action plans in all required instances, and (d) assessing the need to withhold payments or eliminate providers from the program in cases where the provider does not comply with audit requirements.	Agree	July 1, 2002
17	94	Revise the testing requirements for Colorado Indigent Care Program provider audits to ensure audits accurately reflect and report on areas of greatest risk by (a) requiring that auditors base their testing on a sample of charges, verify that CICP recipients were charged amounts consistent with other patients, and confirm that the provider's detailed information supports amounts reported to the Department; (b) revising eligibility testing requirements in order that error rates reflect eligibility determination for the provider that is being audited; and (c) developing a standard form for auditors to use for reporting audit results.	Agree	July 1, 2002
18	98	Continue efforts to implement effective means for communicating program requirements and changes to providers about the Colorado Indigent Care Program and obtaining provider feedback.	Agree	Ongoing

Description

Introduction

The Colorado Indigent Care Program (CICP) was authorized by the General Assembly in House Bill 83-1129, the "Reform Act for the Provision of Health Care for the Indigent." Prior to this, the State had in place a program to partially reimburse providers for care furnished to the medically indigent; however, the program was not formally recognized in statutes. CICP has also been called the Medically Indigent Program and the Colorado Resident Discount Program. Unlike the Medicaid program, CICP is not an entitlement, which means that the State is not legally obligated to serve all individuals who meet the program's eligibility requirements. Through Fiscal Year 1994, CICP was administered by the University of Colorado Health Sciences Center. Under HB 93-1317, the program was placed under the newly created Department of Health Care Policy and Financing (HCPF) in Fiscal Year 1995. In Fiscal Year 2001 the program partially funded services to about 160,100 individuals and made payments to providers of about $131.9 million.

The Colorado Indigent Care Program is a financing mechanism through which the State reimburses participating providers for a portion of the costs incurred in treating individuals that meet CICP eligibility requirements. In turn, participating providers must adhere to state-established limits for amounts charged to CICP-eligible individuals. Thus, CICP promotes access to health care services for low-income uninsured individuals by helping to defray providers' costs of furnishing care and by limiting the amount that individuals receiving the care must pay.

CICP does not qualify as an insurance plan under state law because it does not provide individuals with a policy or agreement that defines a list of benefits to which they are entitled. Statutes limit the program's expenditures to the amount of available appropriations and to each provider's physical, financial, and staff resources. Thus, providers furnish varying levels of benefits. Statutes require that providers manage CICP funds to ensure the following priorities are met:

- Emergency care for the entire year.
- Additional care for conditions the Department determines to be the most serious threat to a medically indigent person's health.
- Other medical care.

Population Served by CICP

CICP finances services to state residents whose combined net income and assets does not exceed 185 percent of the federal poverty level ($32,653 for a family of four as of April 2001) and who are otherwise uninsured or underinsured. Additionally, the person must not be eligible for Medicaid. In calculating net assets, an individual is allowed to exclude up to $4,500 in vehicle equity, $50,000 in business equity, the value of his or her primary residence, $2,500 for each dependent, and specified expenses such as childcare. Copayments under CICP range from zero to $535 and are determined by the type of service (inpatient or outpatient) and the person's financial status. Annual copayments are capped at 10 percent of a family's net income and assets; at the lowest category (zero to 37 percent of the federal poverty level), the annual cap is $120. Under CICP, there are no deductibles, and most services are allowable as long as they are authorized and medically necessary.

CICP serves a high proportion of low-income adults: In Fiscal Year 2001 almost 85 percent of the 160,100 individuals served were over 18 years of age. The relatively high ratio of adults is a result of the fact that Medicaid serves pregnant women and children at the lowest levels of income. Additionally, children in low-income families not qualifying for Medicaid may be eligible for the Children's Basic Health Plan (CBHP), which is marketed under the name "Child Health Plan Plus." Due to the differing eligibility requirements for the three programs, a family could have different members in different programs at the same time. The relationship between these three programs is discussed in Chapter 1.

HCPF reports that the number of individuals receiving CICP services increased close to 20 percent between Fiscal Years 1996 and 2001. However, because of changes the Department made in its methodology for determining the number of individuals served, staff indicate that numbers prior to Fiscal Year 1999 are not wholly comparable to those in subsequent years. Additionally, it is likely that the number served in any particular year is somewhat overstated because the Department does not have an unduplicated count across providers, only within individual providers. In any case, the number served appears to have increased over recent years, as shown in Table 1 below.

Table 1: Number Served Through the Colorado Indigent Care Program
Fiscal Years 1996 Through 2001

	Fiscal Year					
	1996	**1997**	**1998**	**1999**	**2000**	**2001**
Number served[1]	133,722	128,816	160,117	149,097	155,530	160,145
Percent increase from prior year		-3.7%	24.3%	-6.9%	4.3%	3.0%
Percent increase Fiscal Year 1996 through 2001						19.8%

Source: Office of the State Auditor analysis of Department of Health Care Policy and Financing data.

[1] Department staff report that there was a change in the methodology used to count the number served in both Fiscal Years 1998 and 1999. Therefore, numbers reported prior to Fiscal Year 1999 are not necessarily comparable to those in subsequent years. Additionally, the number served may be somewhat inflated because the count is unduplicated within individual providers but not across all providers.

While there is no estimate of how many individuals in Colorado might be eligible for services under CICP, the Kaiser Commission estimates that between 1997 and 1999 Colorado had approximately 358,000 uninsured individuals who were younger than 65 years of age (i.e., did not qualify for Medicare) and had an income of less than 200 percent of the federal poverty level. This is an uninsured rate of about 37.4 percent for that group. Very roughly, less than half of this group appears to receive services through CICP annually.

CICP Providers and Reimbursement for Care

Under statutes, CICP providers must be a facility such as a hospital, birth center, or community health clinic licensed by the Department of Public Health and Environment. Statutes designate Denver Health Medical Center (Denver Health) as the primary provider of indigent care in the City and County of Denver and the University of Colorado Hospital (University Hospital) as the primary provider of indigent care for the Denver metropolitan area. University Hospital primarily serves residents in the metropolitan area outside of the City and County of Denver and furnishes complex care to all areas of the State.

HCPF policies allow other qualifying hospitals in the City and County of Denver to participate in CICP if they either offer unique services or serve a unique population. These

hospitals must furnish at least 50 percent of their CICP care to individuals outside the City and County of Denver. Statutes permit health maintenance organizations to participate in CICP, although none have chosen to do so.

Of the 68 providers participating in Fiscal Year 2002, 20 are public hospitals, 30 are private hospitals, and 18 are clinics. In recent years the number of CICP providers has been stable, with little variation from year to year. In terms of CICP providers' presence across the State, these 68 providers have 143 sites located in 45 of the State's 64 counties. This is illustrated in Appendix A, which also illustrates the types of providers available in each county. In 19 counties, there are no participating providers.

Under CICP, providers are reimbursed for a portion of the uncompensated care furnished to CICP-eligible individuals. Providers annually report uncompensated charges for services furnished to CICP individuals to the Department. From charges, HCPF derives the estimated cost of these services for each provider. This cost estimate serves as the basis upon which providers are reimbursed; thus, the term "reimbursement rate" used in this report refers to the provider's reimbursement payments relative to the provider's estimated CICP costs which are derived from the provider's CICP charges. Further, some CICP hospitals receive other CICP payments in addition to those based on costs derived from CICP charges. The basis for these additional CICP payments is described under "CICP Funding" later in this chapter.

Provider reimbursement rates vary widely depending on (1) the category of the provider and (2) whether or not the provider receives payments in addition to those based on CICP costs derived from CICP charges. Providers are placed into one of three categories on the basis of the type of provider (hospital versus clinic) and the provider's Medicaid utilization level (percentage of Medicaid inpatient days to total inpatient days). Providers with higher Medicaid utilization levels are reimbursed for a higher percentage, or rate, of their CICP costs. The providers in this category also receive the additional CICP payments that are not linked directly to charges.

In Fiscal Year 2001, providers were paid a total of $131.9 million. Of this, $89.3 million was paid on the basis of CICP charges, and average reimbursement rates, based on provider categories, ranged from 27 percent to 51.6 percent of CICP costs. Additional payments of $42.6 million were paid to providers in the category with higher Medicaid utilization, which raised the overall average reimbursement rate for that category to 83.3 percent of CICP costs. Reimbursement rates are discussed in more detail in Chapter 1, and the reimbursement process is discussed in Chapter 2.

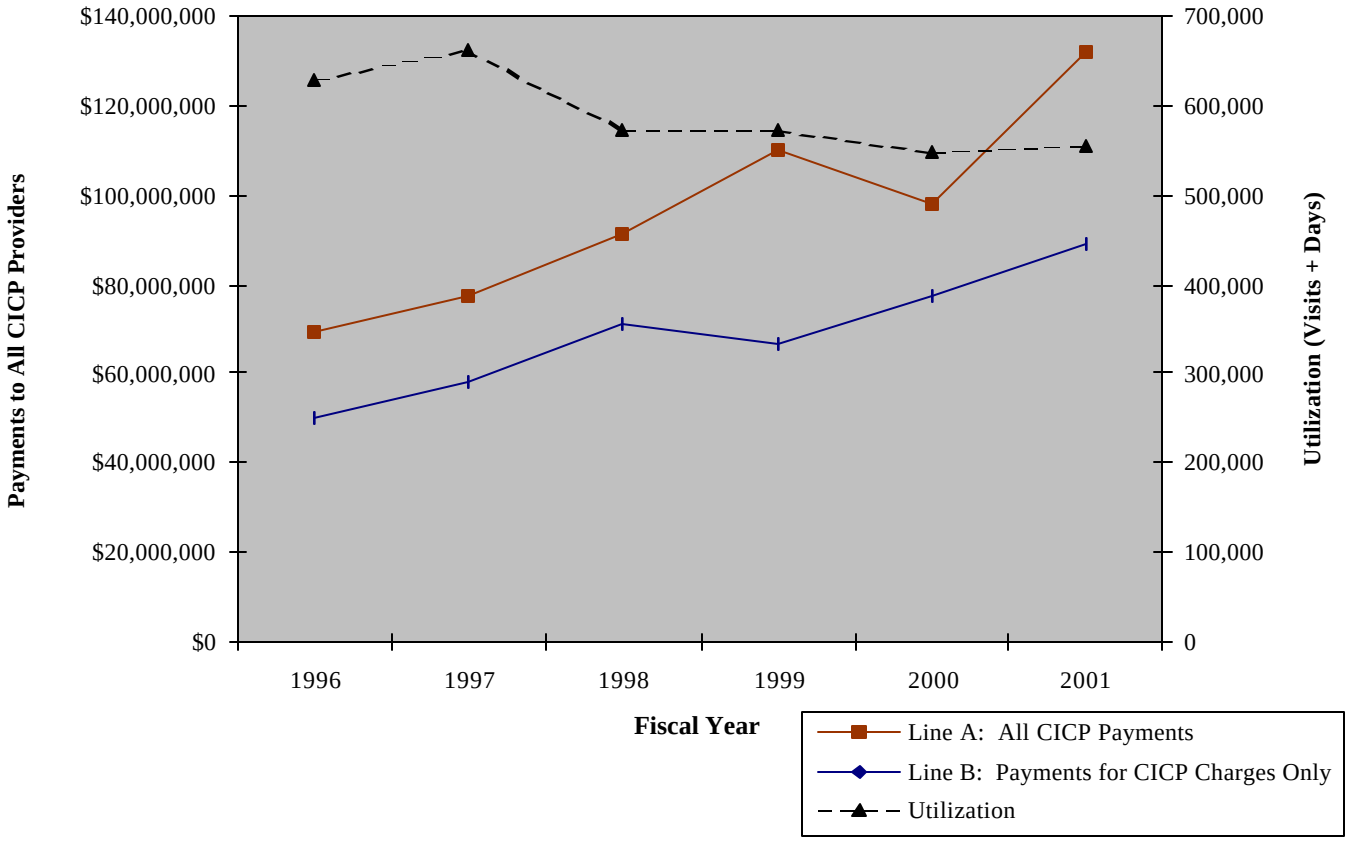
Relationship Between Reimbursement and Utilization

There is not a direct relationship between payments to providers and utilization by individuals, because of the variations in reimbursement rates and the fact that not all payments are linked to CICP charges and costs (i.e., CICP costs derived from CICP charges). This relationship is complicated by other factors as well. Payments to providers are affected by budgetary conditions and the availability of state general funds and federal funds. Over the years, while general funds have been limited, the State has attempted to maximize federal funds as a way to increase payments to qualifying CICP providers and thus strengthen the State's health care safety net. On the other hand, utilization of CICP services can be affected by the State's economy, with downturns resulting in greater demand. Further, a provider's ability to furnish care is affected by the rising costs of medical care, which may limit the services a provider can offer, and this in turn is reflected in CICP utilization.

The lack of direct correlation between utilization and payments over the years is demonstrated in Table 2 below. Utilization is measured by adding together the number of outpatient visits and the number of inpatient hospital days across all CICP providers from Fiscal Years 1996 through 2001. By this measure the utilization for the period has fallen from about 628,000 in Fiscal Year 1996 to about 555,000 in Fiscal Year 2001, or about 12 percent. Most of this decline appears in Fiscal Year 1998. However, as noted with respect to Table 1 earlier in this chapter, the Department changed its methodology for counting individuals in CICP in both Fiscal Years 1998 and 1999. HCPF reports that these changes probably affected utilization numbers as well, and thus, utilization numbers prior to Fiscal Year 1999, may not be entirely comparable to subsequent years. Since Fiscal Year 1999, utilization has been fairly level, with a slight increase in Fiscal Year 2001.

Table 2 also describes how payments to providers have risen between Fiscal Years 1996 and 2001. The upper solid line (Line A) shows that total payments to providers have increased from about $69.7 million to about $131.9 million, or approximately 89 percent. When adjusted for the rate of inflation for medical services during this time, the increase is about 49 percent. These amounts include all CICP payments to providers, not just payments related to CICP charges. The lower payment line (Line B) reflects only those payments made to providers that are based on CICP charges. These payments have increased from about $50 million to approximately $89.3 million, or about 79 percent. When these payments are adjusted for inflation, the increase is about 41 percent.

Table 2: Colorado Indigent Care Program
Utilization Versus Provider Payments[1], Fiscal Years 1996-2001



Source: Office of the State Auditor analysis of Department of Health Care Policy and Financing data.

[1] Provider payments are net of donations to the State made by some hospitals participating in CICP during Fiscal Years 1996 through 2000. These donations were made for various health care programs such as the Children's Basic Health Plan. In addition, payments do not reflect any expenditures certified by public hospitals under CICP.

CICP Funding

CICP is largely funded by federal funds. In Fiscal Year 2001, total provider payments of $131.9 million were funded by $115.0 million in federal funds (87 percent) and $16.9 million in state general funds (13 percent). Table 3 shows the funding source for provider payments over the last three years. As can be seen, the use of state general funds has generally fallen over this period. The decreased use of general funds has resulted from the

increased use of "certification of expenditures" (certification is discussed in Chapter 1). The amount of federal funds in CICP has increased for all three years shown in the table.

Table 3: Colorado Indigent Care Program
Provider Payments[1] by Source of Funds
Fiscal Years 1999 Through 2001
(Dollars in Millions)

	Fiscal Year		
Source of Funds	**1999**	**2000**	**2001**
General Funds	**$36.7**	**$14.9**	**$16.9**
Percent of Total Payments	33.3%	15.2%	12.8%
Federal Funds	**$73.6**	**$83.3**	**$115.0**
Percent of Total Payments	66.7%	84.8%	87.2%
Total Payments, All Sources	**$110.3**	**$98.2**	**$131.9**

Source: Office of the State Auditor analysis of Department of Health Care Policy and Financing data.

[1] Includes all CICP payments to providers: payments based on CICP charges, bad debt payments, and Major Teaching Hospital payments.

This trend in CICP of decreasing general funds and increasing federal funds began in Fiscal Year 1990 when federal funds were first used for the program. Prior to that year, CICP was funded entirely with state general funds.

In Fiscal Year 1990 the former Department of Social Services (DSS) received approval from the federal government for the first of several amendments to the State Plan for the Medicaid program that were intended to access more federal funds for low-income care in Colorado. DSS administered the Medicaid program until the restructuring of state government under HB93-1317. As of Fiscal Year 1995, the Medicaid program has been administered by the Department of Health Care Policy and Financing.

Currently HCPF has the following financing mechanisms in place under the State Plan for low-income care. The first year the mechanism was used is also shown.

- **Major Teaching Hospital program (MTH)** (Fiscal Year 1990). These hospitals must be teaching hospitals and must meet criteria related to the number of interns and resident FTEs. Additionally, their combined Medicaid days and CICP days must equal or exceed 30 percent of their total patient days. Denver

Health and University Hospital are the only providers that qualify as MTH facilities under the State Plan. These payments are intended to reimburse hospitals for the difference between amounts reimbursed under Medicaid and amounts that would have been reimbursed under Medicare for the same services. These payments are not based on CICP charges and costs; rather, the payments are allocated according to the providers' Medicaid days and medically indigent days.

- **Disproportionate Share Hospital program (DSH)**. In general, DSH provisions allow additional payments of federal funds to Medicaid hospitals that serve a disproportionate number of Medicaid and other low-income patients. These facilities have a limited ability to shift costs to privately insured patients, and payments are intended to help these hospitals remain financially viable. Federal law requires that hospitals with either a Medicaid inpatient utilization rate of one standard deviation above the mean rate for all Medicaid hospitals in the state or a low-income utilization rate that exceeds 25 percent receive DSH payments in addition to regular Medicaid payments. The Precomponent 1 payments described below are the State's initial effort to meet these federal requirements. Subsequent amendments were put in place to make additional DSH payments to hospitals. The federal government imposes limits on the amount of DSH funds available to each state under each annual federal award.

  Precomponent 1[1] (Fiscal Year 1991). These hospitals must have a Medicaid inpatient utilization rate that is one standard deviation above the mean rate for all Medicaid hospitals in the State. Payments are made as an add-on to the provider's base Medicaid payment rate. These hospitals do not have to be CICP providers.

  Component 1A (Fiscal Year 1994). Same Medicaid inpatient utilization rate as Precomponent 1 hospitals. In addition, hospitals must participate in CICP. Payments are based on CICP charges and estimated costs.

  Outstate hospital (Fiscal Year 1995). These hospitals must have an inpatient Medicaid utilization rate of at least 1 percent. Further, qualifying hospitals must participate in CICP. Payments are based on CICP charges and estimated costs.

[1] Since Precomponent 1 funds are not linked to CICP services and charges and these providers do not have to participate in CICP, these funds are not reflected in financial information in this report unless otherwise noted.

Bad debt (Fiscal Year 1995). HCPF uses this mechanism at the end of the federal award period to "backfill" DSH expenditures in order to spend as close as possible to the federally imposed DSH cap, or maximum, for the State under each federal award. To receive these payments, the hospital must be a Component 1A provider and, therefore, a CICP provider. Payments are used to reimburse a portion of providers' bad debt from all non-paying patients, including CICP patients. Thus, these payments are not based on CICP charges and costs.

State general funds are used to fund all payments to clinics in CICP because they are not inpatient facilities and therefore cannot qualify for DSH payments; these providers are referred to as Outstate Clinics. General funds are also used as the nonfederal match for payments to private hospitals, which cannot certify expenditures under federal regulations. As mentioned earlier, certification of expenditures is discussed in Chapter 1.

Maximization of DSH Payments

DSH funds are the State's primary source of federal funds for indigent care. For example, in Fiscal Year 2001, out of the $115 million in federal funds used to make provider payments, $93.8 million was from DSH funds and $21.2 million was from Major Teaching Hospital funds.

The Department's objective is to maximize CICP payments up to the federally established caps for DSH funds for each federal award, and it has been fairly successful in this effort. As illustrated by Table 4, Colorado's DSH expenditures have varied with the amount of DSH funds available; however, Colorado has spent from about 95 percent to as much as 99 percent of available DSH funds for the award periods shown. Each award period is for two years; for example, the State has until September 30, 2002, to draw monies against the Federal Fiscal Year 2000 award. With respect to amounts still available under the Federal Fiscal Year 2000 and 2001 awards, the Department would need to submit a supplemental budget request to the General Assembly in order to expend these funds.

Table 4. Colorado's Disproportionate Share Hospital (DSH) Allotments and Expenditures, Federal Funds Share
Federal Fiscal Award Years 1998 Through 2001

Award Year (Federal Fiscal Year[1])	DSH Allotment[2]	DSH Expenditures[4]	Unused DSH Allotment	% of DSH Allotment Used
1998	$93,000,000	$88,127,284	$4,872,716	94.8%
1999	$85,000,000	$84,502,101	$497,899	99.4%
2000	$79,000,000	$78,372,111	$627,889	99.2%
2001	$81,765,000[3]	$79,431,688	$2,333,312	97.1%

Source: Office of the State Auditor analysis of Department of Health Care Policy and Financing data submitted on quarterly federal Medicaid reports.

[1] The federal fiscal year is from October 1 through September 30. Thus, Federal Fiscal Year 1998 is from October 1, 1997, through September 30, 1998. Each allotment is available for a two-year period.

[2] DSH allotments as set for Colorado in the Balanced Budget Act of 1997.

[3] Federal Fiscal Year 2001 DSH allotment as adjusted by the Balanced Budget Refinement Act of 1999.

[4] Includes federal funds expended for Precomponent 1, Component 1A, Outstate hospitals, and bad debt financing mechanisms under the DSH program.

In the future the State could face more pressure to finance the Colorado Indigent Care Program. Under current federal laws, the federal cap for Colorado's DSH allotment for Federal Fiscal Year 2002 is $83.9 million, an increase of over $2 million. However, the Department reports that Colorado's Federal Fiscal Year 2003 allotment will be reduced to about $75.9 million unless additional federal legislation is enacted.

Program Administration

The Department of Health Care Policy and Financing is responsible for administering CICP, and three full-time equivalents (FTE) are appropriated to the program. The staff includes a program manager, an eligibility specialist, and an information systems specialist. Administrative expenditures for personnel ($173,200 including benefits), operating costs ($21,000), and information system services ($100,000) were about $294,200 for Fiscal Year 2001. This is an increase of about 5.6 percent from Fiscal Year 1999 when administrative expenditures were $278,600.

HCPF has elected to have the Medical Services Board (Board) serve as the rule-making body for the Colorado Indigent Care Program, although statutes do not require that the

Board perform this function. The Board also sets rules for the Medicaid program and the Children's Basic Health Plan.

HCPF's duties include:

- Establishing program policies and procedures and proposing rules to the Medical Services Board as necessary.

- Executing contracts with providers for payment of costs and medical services, allocating available funds among providers and issuing payments, compiling data from providers on CICP services and individuals served, and otherwise communicating with providers as needed to oversee and assist with program operations.

- Ensuring requirements in the State Plan for the Medicaid program are met with respect to the federal funds used to support CICP and proposing amendments to the State Plan as needed to the Board and the federal government.

Additionally, the Department submits a statutorily required annual report to the General Assembly that includes a variety of information about the program. The annual report documents eligibility requirements, method of allocating and disbursing funds to providers, amounts paid to providers, CICP services, and number served.

Providers have the following responsibilities under CICP:

- Determining eligibility for CICP and meeting program requirements established by the State, including annual audit requirements.

- Providing allowable services within their resources and in accordance with established legislative medical services priorities. Providers are also responsible for collecting patient copayments and third party payments, when applicable.

- Submitting required information to HCPF regarding charges incurred and services provided on behalf of CICP patients.

The Department's oversight procedures and other administrative aspects of CICP are discussed in Chapter 3.

Colorado Health Care Task Force

The original legislation for CICP established the Joint Review Committee for the Indigent (Committee) for the purpose of giving guidance and direction to the indigent care program. House Bill 99-1019 repealed the section creating the Committee and established the Colorado Health Care Task Force (Task Force), which is composed of 10 members of the General Assembly. The Task Force has much broader responsibilities and is charged with gathering information and formulating "legislation if necessary for the proper operation of the health care system in this state" (Sec. 26-15-107(1)(b), C.R.S.).

Audit Scope and Methodology

We reviewed documentation and interviewed personnel for the Colorado Indigent Care Program at the Department of Health Care Policy and Financing with respect to program policies, procedures, and operations; provider reimbursement methodologies, calculations, and payments; and program oversight. We interviewed selected providers and stakeholder groups, conducted a survey across a sample of 25 hospitals and clinics, and performed detailed analysis and testing on a sample of charges submitted to the Department for CICP.

Policy Issues

Chapter 1

Introduction

The Colorado Indigent Care Program (CICP) promotes access to health care for state residents who are uninsured or lack adequate insurance (e.g., their benefits are exhausted or limited) and are not eligible for Medicaid. Additionally, eligible individuals cannot have financial resources (net income and assets) that exceed 185 percent of the federal poverty level. Under CICP, the State partially reimburses providers who serve CICP-eligible individuals; in Fiscal Year 2001, participating providers were paid a total of $131.9 million. The program is administered by the Department of Health Care Policy and Financing (HCPF).

CICP was not designed or intended to be an insurance plan and does not qualify as one under state law. Statutes describe the program as a "partial solution to the health care needs of Colorado's medically indigent citizens" (Sec. 26-15-102 (2), C.R.S.). In practice, CICP is a set of financing mechanisms that channels funds to hospitals and clinics as an offset to losses they incur from serving medically indigent state residents. Unlike Medicaid or the Children's Basic Health Plan, CICP is not an eligibility program with a set of beneficiaries that receives a defined package of services.

As noted earlier, for Fiscal Year 2002 there are 68 hospitals and clinics that participate in CICP. Providers are classified into one of three categories on the basis of whether the provider is a clinic or a hospital. All clinics are classified into the "Outstate clinic" category. Among the hospitals, providers must have a Medicaid utilization rate of at least 1 percent, based on inpatient days, to participate in CICP. Hospitals that have a Medicaid utilization rate of one standard deviation above the mean for all hospitals in the State are classified as "Component 1A providers." For example, in Fiscal Year 2001 the mean Medicaid utilization rate for the State was 13.8 percent, based on inpatient days. Hospitals meeting the one standard deviation rule had Medicaid utilization rates of at least 25 percent, or almost twice the average Medicaid utilization rate of other Medicaid hospitals in Colorado. If a hospital's Medicaid utilization is below one standard deviation, it is classified as an "Outstate hospital." All hospitals are eligible to receive federal funds under the Disproportionate Share Hospital program (DSH), which is the State's primary source of

federal funds for CICP. Clinics are not eligible for DSH funds and are paid solely from state general funds. In Fiscal Year 2002, CICP includes:

- 9 Component 1A hospitals.
- 41 Outstate hospitals.
- 18 Outstate clinics.

Our audit reviewed the financing mechanisms used to fund indigent care payments to providers, reimbursement calculations and procedures, and the Department's oversight mechanisms for CICP. Additionally, we assessed the program's compliance with its enabling legislation, the "Reform Act for the Provision of Health Care for the Indigent" (Title 26, Article 15), as amended.

During the audit we identified two areas in which state policy needs to be reevaluated. These are as follows.

Basis for determining CICP payments to providers. The State should reassess the basis on which payments are made to providers under CICP in order to ensure that payments are determined on an accurate and equitable basis. This requires examining some fundamental aspects of the program.

Role of clinics; reimbursements in excess of CICP costs. There are several respects in which CICP has evolved over the years that are not entirely consistent with program statutes. The primary example is the role of the clinics, which have long been accepted as a critical component of CICP despite the fact that they are not designed or intended to meet the medical services priorities established in statute (e.g., provide emergency medical services for the entire year). Second, certain providers receive CICP payments that in total exceed the amount of their CICP costs. Statutes state that providers are not to be funded at levels that exceed these costs; however, because of additional payments to some providers for bad debt (discussed in the Description chapter), this has occurred in some instances.

These two policy areas are discussed in this chapter, along with options the State could consider. This chapter also addresses the relationship between CICP, Medicaid, and the Children's Basic Health Plan. All of these programs provide health care services to low-income state residents.

The remaining chapters of this report describe our findings with respect to how the program currently operates. The recommendations in those chapters are based on the assumption that the State chooses to continue to operate CICP without major policy changes.

Basis For Determining Payments to CICP Providers

The Colorado Indigent Care Program as it presently operates raises concerns about equity for two reasons. First, the program lacks sufficient administrative oversight to ensure the accuracy of the CICP charges submitted by providers. This is a problem because CICP costs derived from CICP charges are used as the basis for determining the majority of providers' reimbursement. Either the administrative oversight of the program should be significantly strengthened or the program should be structured differently. Equity concerns are particularly important because each of the three provider categories is paid from a separate pool of funds. If one provider in the category is overpaid, then less funding is available to other providers in that category. Therefore, the Department must ensure that payments are based on comparable data from providers and are calculated consistently for each category.

The second reason for concerns about equity is that the rate of reimbursement a provider receives (i.e., provider's CICP payment ÷ provider's CICP costs) is not necessarily based on the volume of services it renders to CICP individuals. If the program is to continue to base payments on CICP charges and costs, (i.e., CICP costs derived from CICP charges) and the intent is to encourage providers to furnish services to CICP individuals, then the State should consider ways in which it could more directly link CICP payments to the level of CICP services rendered. For example, in Fiscal Year 2001:

- One Outstate hospital had CICP costs of about $3.6 million and received reimbursement of $977,500, or about 27 percent of CICP costs.

- A Component 1A hospital had CICP costs of about $3.8 million, or slightly above the costs of the Outstate hospital, and received reimbursement of $3.6 million, or about 95 percent of CICP costs. This does not include the additional payments to the Component 1A provider of over $1 million made on the basis of that provider's bad debt.

CICP Charges

Each year, CICP providers are responsible for submitting to the Department information on their charges for CICP services and related adjustments, such as deductions for patient copayments and payments from other insurance companies. As discussed in Chapter 2, HCPF uses these charges and adjustments to estimate CICP costs. The appropriate reimbursement rate for the provider's category is then applied to these CICP costs to

arrive at the payment amount, which is paid in installments throughout the fiscal year. HCPF uses a prospective payment method, which means that CICP charges and costs (i.e., CICP costs derived from CICP charges) from two years prior are used as the basis for calculating payments in the current fiscal year.

Our audit found that the Department does not have sufficient administrative oversight of the program to ensure that the reported information is correct and that payments are accurate and equitable across all providers. For example, the Department does not audit any of the charges submitted. We tested a sample of CICP charges and found one provider was billing the State for charges disallowed under federal Medicare regulations. We estimated that HCPF had overstated this provider's Fiscal Year 2002 reimbursement by about $2 million because of these disallowed charges. This means that there was $2 million less available for other providers in the Component 1A category.

We also identified problems with the data on CICP charges submitted to HCPF. In some instances, the Department does not receive a detailed listing of the charges; the provider submits only a one-line summary for certain charges and adjustments. We requested detailed charges for summary information from two providers and found both providers had difficulty furnishing these data, in part because they had not maintained all data. When reviewing the data prior to furnishing it to us, one provider discovered it had erroneously overstated CICP charges by about $3 million. One CICP subcontractor identified a total of almost $2.2 million in duplicate charges that were submitted for CICP through two other providers. These errors likely would have gone undetected if we had not made our request. The overstated charges resulted in an overstatement of providers' Fiscal Year 2002 reimbursements by about $1.7 million. Again, this resulted in $1.7 million less in available funds for other providers in the Component 1A category.

The Department's only independent assessment of providers' compliance with CICP requirements is the annual audit requirement for providers. We found that the Department does not systematically review the provider audits to ensure that all audits have been received and that problems identified are resolved. For Fiscal Year 1999, the most recent year for which all audits should have been submitted, we found that 14 (20.9 percent) were not on file at HCPF; these providers were paid in total almost $2.6 million under CICP for that year. There were two providers that had no audits on file for three years, and five that had no audits on file for two years. During our provider survey, one provider said that it was not aware the program had an audit requirement. Additionally, we reviewed a sample of 25 audits for Fiscal Year 1999 and identified 7 that had sufficiently high error rates to require the submission of a corrective action plan with the audit. Only one had done so, and we did not note evidence of follow-up by HCPF staff to obtain the six missing plans. Finally, our review of the requirements that auditors are to test indicated that the requirements are not adequate to identify problems with CICP charges. This is

demonstrated by the fact that during our testing of CICP charges, we found one provider who was submitting federally disallowed charges.

Additionally, we reviewed the Department's processes for calculating provider reimbursements. We identified a $1.4 million overstatement in one provider's Fiscal Year 2002 payment due to staff's calculation errors. In other instances, we found a lack of consistency and documentation that could have resulted in other errors' going undetected. We also noted that the methodology used to calculate reimbursements for one category of providers uses outdated and inaccurate information that affects the equity of payments for those providers.

Table 5 below summarizes the errors in projected Fiscal Year 2002 payments identified during our audit of CICP. These errors resulted in fewer available funds for other Component 1A providers.

Table 5: Colorado Indigent Care Program
Summary of Errors Identified in OSA Audit
Fiscal Year 2002 Payments

Description of Error	Projected Overpayment for Fiscal Year 2002
Overstatement of CICP charges due to provider's failure to deduct disallowed charges under Medicare from CICP charges.	$2 million
Overstatement of CICP charges due to providers' erroneously including incorrect amounts in CICP charges.	$1.7 million
Calculation error by HCPF.	$1.4 million
Total projected overpayments identified during OSA audit	**$5.1 million**

Source: Office of the State Auditor analysis of Department of Health Care Policy and Financing and provider data.

Finally, we found that CICP appears to have a significant overlap with the Medicaid program. Under CICP regulations, persons eligible for Medicaid cannot be served in CICP. We tested CICP charges submitted by providers for services rendered in April 2000, and we identified 1,622 individuals for whom CICP charges were submitted to HCPF, even though the individual was Medicaid-eligible at the time of receiving services. We estimate that these providers would have received about $554,800 in reimbursement

based on the CICP charges for these individuals. In almost half of these cases, the individual had been determined eligible for Medicaid at least three months prior to April 2000. In the remaining cases, it is possible that providers may have made retroactive adjustments that reversed the CICP charges. However, the Department has no effective way in which to determine that such adjustments are made and is dependent upon the providers' controls to identify and correct CICP charges in cases where retroactive adjustments are needed.

Options for the State

Because of the problems described above, we believe that the State needs to evaluate the options for reimbursing providers under CICP and consider the best direction for the program. In other words, the State should reconsider whether CICP payments should be based on CICP charges.

Option 1: Continue to use CICP costs derived from CICP charges as the basis for provider reimbursement.

The first option is to continue to base CICP payments to providers on CICP costs derived from CICP charges. This has the advantage of linking reimbursement to the level of services a provider renders to CICP eligibles. This has historically been the primary basis of provider reimbursement under CICP.

The disadvantage of this option is demonstrated by the problems identified in our audit, which are primarily related to problems with the CICP charges reported by providers and the administrative oversight required to ensure these charges are accurate and allowable. Therefore, if the State chooses to continue to use CICP costs derived from CICP charges as the basis for reimbursement, the administrative oversight of the program must be decisively improved. Most of the recommendations in this report concern steps that must be taken to ensure provider payments are accurate and equitable.

Additionally, if CICP costs derived from CICP charges are to continue to be the basis of payments, the State should take steps to address some of the disparities in reimbursement rates among providers. As presently structured, CICP reimbursement rates are based on a provider's Medicaid utilization. Providers in the Component 1A category, which have relatively high Medicaid utilization, have always received higher reimbursement rates than those in the Outstate categories. Further, Component 1A providers are the only providers that receive additional CICP payments, primarily for bad debt, that are not based on CICP charges and derived CICP costs. This increases the overall disparity in reimbursement levels. In extreme cases, these extra payments result in providers' receiving reimbursement

in excess of their CICP costs. For example, in Fiscal Year 2001 one Component 1A provider received reimbursement of 49.6 percent on the basis of its CICP costs for that year. However, when bad debt payments are included, this provider was paid 199.7 percent of its CICP costs.

Our analysis indicates that providers with high Medicaid utilization levels do not always furnish the highest volume of CICP services. For example, in Fiscal Year 2001, out of all 66 providers, there were 6 that had CICP charges in excess of $10 million. However, only two of these six providers were in the Component 1A hospital category and received the higher reimbursement rates.

Using a different analysis, we found that in Fiscal Year 2000 there were 20 Outstate hospitals that had a higher percentage of CICP charges with respect to their total facility charges than at least one of the providers in the Component 1A category. In other words, these 20 Outstate hospitals rendered relatively more CICP services than at least one of the Component 1A hospitals, yet the Outstate hospitals received considerably lower reimbursement rates than Component 1A hospitals.

If the intent is to encourage providers to furnish CICP services, the State should consider using other factors when setting reimbursement rates for providers in addition to their Medicaid utilization. For example, higher reimbursement rates could be paid based on the volume of CICP services.

Variation of Reimbursement Rates Among Categories. The reimbursement rates can vary considerably among categories, especially when all CICP provider payments are considered. This is illustrated in Table 6 below. For example, in Fiscal Year 2001 the Outstate Clinics and Outstate Hospitals categories each received reimbursement rates of 27 percent of their CICP costs. No additional CICP payments were made to these providers other than those based on CICP costs. Component 1A hospitals received an average reimbursement rate of 51.6 percent of their CICP costs. When additional payments totaling $42.6 million under the Major Teaching Hospital program and bad debt payments are included, the reimbursement rate for these hospitals increases to an average of 83.3 percent of CICP costs.

Table 6: Colorado Indigent Care Program
Payments and Reimbursement Rates[1] for All CICP Providers
Fiscal Years 1999 Through 2001
(Dollars in Millions)

Provider Category	Fiscal Year		
	1999	2000	2001
Outstate Clinics			
Payments based on CICP costs	$4.8	$4.4	$4.9
Rate	30.0%	24.0%	27.0%
Outstate Hospitals			
Payments based on CICP costs	$11.0	$10.2	$15.0
Rate	30.0%	24.0%	27.0%
Component 1A Hospitals			
Payments based on CICP costs	$50.8	$63.0	$69.4
Rate	41.6%	47.6%	51.6%
Bad debt and Major Teaching payments[2]	$43.7	$20.6	$42.6
Subtotal: Component 1A Hospitals, All Payments	$94.5	$83.6	$112.0
Rate	77.4%	63.2%	83.3%
Total: All Categories and Payments			
Payments based on CICP costs	$66.6	$77.6	$89.3
Bad debt and Major Teaching payments[2]	$43.7	$20.6	$42.6
Total: All Payments	***$110.3***	***$98.2***	***$131.9***
Rate	***63.1%***	***50.9%***	***63.3%***

Source: Office of the State Auditor analysis of Department of Health Care Policy and Financing data.

[1] Reimbursement rates are calculated as the amount of CICP payments paid by the State to a provider divided by the provider's CICP costs. These costs are not shown in this table. Reimbursement rates are averages for all the providers in the category indicated; rates can also vary for individual providers within categories.

[2] Additional payments include bad debt and Major Teaching Hospital payments that are intended to assist qualifying hospitals with the cost of low-income care; however, these payments are not calculated based on CICP costs. Bad debt payments were made only in Fiscal Years 1999 and 2001. Major Teaching Hospital payments were made in all three fiscal years shown.

Variation of Reimbursement Rates Within Categories. Within the Component 1A category itself, reimbursement rates can vary substantially. Some variation occurs because the Department uses a prospective payment methodology, meaning that in these cases providers' payments for CICP services are based on CICP charges and the derived CICP costs from two years prior. No adjustment is made at the end of the year to reconcile estimated CICP costs to actual CICP costs for the year.

While this type of variation is to be expected under a prospective payment methodology, this is not the primary source of variations among Component 1A providers. Table 7 illustrates additional detail on the variations in reimbursement rates and payments for these hospitals.

Table 7: Colorado Indigent Care Program
Payments and Reimbursement Rates[1] for Component 1A Providers Only
Fiscal Years 1999 Through 2001
(Dollars in Millions)

Provider	Fiscal Year		
	1999	2000	2001
Denver Health			
Payments based on CICP costs	$32.0	$37.1	$38.9
Rate	45.0%	46.7%	47.2%
Payments based on CICP costs, plus bad debt and Major Teaching payments[3]	$56.1	$47.4	$65.0
Rate	78.9%	59.7%	78.8%
University Hospital			
Payments based on CICP costs	$15.0	$18.8	$22.9
Rate	33.5%	41.5%	52.0%
Payments based on CICP costs, plus bad debt and Major Teaching payments[3]	$29.4	$29.1	$36.0
Rate	65.5%	64.2%	81.7%
All Other Component 1A Hospitals[2]			
Payments based on CICP costs	$3.8	$7.1	$7.6
Rate	62.0%	94.1%	95.4%
Payments based on CICP costs, plus bad debt payments[3]	$9.0	$7.1	$11.0
Rate	145.7%	94.1%	138.4%

Source: Office of the State Auditor analysis of Department of Health Care Policy and Financing data.

[1] Reimbursement rates are calculated as the amount of CICP payments paid by the State to a provider divided by the provider's CICP costs. These costs are not shown in this table. Reimbursement rates are averages for all the providers in the group indicated; rates can also vary for individual providers within groups.

[2] Full detail for these Component 1A Hospitals can be found in Appendix B of the report.

[3] These payments are not based on CICP costs. Bad debt payments are based on the providers' bad debt from prior years and were made only in Fiscal Year 1999 and Fiscal Year 2001. Major Teaching Hospital payments were made in all three fiscal years shown; only Denver Health and University Hospital qualify as teaching hospitals under the State Plan for the Medicaid program.

As Table 7 shows, in Fiscal Year 2001 Denver Health and University Hospital received reimbursement rates of 47.2 percent and 52 percent on the basis of their CICP costs; other Component 1A providers received an average of 95.4 percent reimbursement on the basis of their CICP costs. When all CICP payments are included, Denver Health and University Hospital received reimbursement rates of 78.8 percent and 81.7 percent, respectively; other Component 1A providers received 138.4 percent. Appendix B of this report shows the breakdown by individual providers for all hospitals in the Component 1A category.

The reason Denver Health and University Hospital receive significantly lower reimbursement rates than the other Component 1A hospitals is that these two providers are both public hospitals. Therefore, under federal regulations the State is allowed to have these two providers "certify" their CICP expenditures or costs, and in turn, the State uses these certified expenditures as the basis for drawing federal funds. In other words, certification of public expenditures by these entities is used in place of the State's spending state general funds as the basis for drawing down federal funds. The State then passes through to Denver Health and University Hospital the federal matching funds it receives on the basis of the certified expenditures. For example, if Denver Health certifies $100 million in CICP costs, the State will receive $50 million in federal matching funds (the 50 percent matching rate under the Medicaid program) that are then paid to Denver Health. Because of the use of certification, neither Denver Health nor University Hospital receives state general funds as part of their CICP payments.

On the other hand, the other Component 1A providers are private hospitals and cannot certify expenditures under federal regulations. Therefore, these providers receive both state general funds and federal funds in their Component 1A payments. As a result, their reimbursement rates based on CICP costs are roughly twice that of the two public hospitals.

Denver Health and University Hospital both receive Major Teaching Hospital funds, which other Component 1A providers do not receive; and these payments help to make up for some of the disparity in the reimbursement rates between the public and private hospitals in this category. All Component 1A hospitals receive bad debt payments when these payments are authorized by the General Assembly.

Option 2: Change the basis for calculating provider reimbursements for CICP.

The second option is to use a basis other than CICP costs derived from CICP charges to determine provider reimbursements. In order to avoid the administrative oversight problems that occur with using CICP charges, this alternative would have to be based on

information that HCPF already has and over which there are adequate controls in place to ensure its accuracy and reliability.

One alternative would be to link CICP payments to Medicaid utilization in some manner. The Department administers the Medicaid program, and it has access to a wealth of data through the Medicaid Management Information System, which processes claims for the Medicaid program. Since the State receives a capped amount of DSH funds each year, the Department would need to develop some method of distributing funds among CICP providers on the basis of a utilization measure or measures from the Medicaid program (e.g., outpatient visits, inpatient admissions or days, individuals served, or some combination).

The advantages of using a substitute measure for CICP charges based on Medicaid data are that the Department already has these data and the data are subject to ongoing internal and external reviews. However, the Department could explore other options that measure low-income care to use as a proxy for collecting detailed information on CICP charges. By eliminating the need to track and collect information on CICP charges, the Department could simplify the administration of CICP. Providers under CICP would still need to determine eligibility for the program in order to ensure the appropriate population receives CICP services, and the Department would need to perform oversight with respect to this function. However, providers would no longer need to collect and report CICP charges, and the Department would not have to ensure the accuracy of these charges.

The disadvantage of using a substitute measure for CICP charges is that, inevitably, any substitute will not measure exactly the same data as CICP charges. Thus, some providers will "win" and other providers will "lose" under a different arrangement. Additionally, over time the Department could not know the extent to which the new measure and CICP utilization might diverge, since CICP charges would not be collected. Finally, changing the basis for payments would require changes in program statutes.

Concerning the use of Medicaid data, our preliminary statistical analysis comparing CICP charges with inpatient Medicaid days across CICP providers for one year indicates that there is a fairly strong relationship between these two measures. However, as we mentioned previously, we also found that some CICP providers with high volumes of CICP charges had relatively low Medicaid utilization rates. Any alternative basis for paying CICP providers would require careful analysis and consideration.

Despite these disadvantages, the State should give serious consideration to using existing Medicaid data, or some other reasonable measure, as the basis for making provider payments under CICP. Under the Health Insurance Portability and Accountability Act, which is intended to ensure the privacy of health care information, the Department may not

be able to receive detailed data from CICP providers for program charges in the future (this is discussed further in Chapter 3). This will increase the need for HCPF to perform on-site audits of CICP charges to ensure their accuracy, thus increasing the demand on limited administrative resources.

Although providers' relative share of CICP monies would change to some degree under any new payment methodology, providers' administrative burden would decrease because data submission requirements, which have been historically problematic under CICP, would be eliminated. In any case, whatever alternative basis the Department elects to use, there must be adequate controls over the data in order to ensure that provider payments under CICP are accurate and equitable.

Recommendation No. 1:

The Department of Health Care Policy and Financing should present options for making provider payments under the Colorado Indigent Care Program by:

a. Developing alternatives to using CICP costs derived from CICP charges as the basis for provider reimbursements under the Colorado Indigent Care Program. For example, alternatives could use Medicaid data or some other measure of low-income care as the basis for calculating CICP payments to providers. Alternatives should include an assessment of the administrative burden on the Department and on CICP providers.

b. For alternatives that continue to use CICP charges as the basis for reimbursement, investigating ways to link provider payments more directly to the volume of CICP services rendered by participating providers

The Department should furnish a report to the General Assembly on these options by December 1, 2002.

Department of Health Care Policy and Financing Response:

Agree. The Department will submit a report by December 1, 2002, to the General Assembly that examines alternatives to using CICP charges as the basis for provider reimbursement and ways to link provider payments more directly to the volume of qualified services rendered by providers. This report will examine the equity of payments, the method of payment and how care is prioritized relative to

the reimbursement level. Any change in the payment methodology would be requested through the Governor's Office of State Planning and Budgeting and presented to the General Assembly.

Role of Clinics

The original legislation for the Colorado Indigent Care Program was enacted in 1983. A number of changes to the statute have occurred since then, with the most substantial being changes required as a result of the movement of the program from the University of Colorado Health Sciences Center to the Department of Health Care Policy and Financing effective Fiscal Year 1995. Aside from this change, the statutory modifications have been fairly minor in terms of impact on program operations.

Over the years, CICP has evolved, and in some instances, the manner in which the program currently operates is not consistent with statutory language. In most cases, these discrepancies are relatively minor. However, in two instances this discrepancy between statutes and operations is more substantial and should be addressed.

Clinics and CICP

The first discrepancy concerns the role of clinics in the Colorado Indigent Care Program. Statutes state that the purpose of the program is to:

> . . . allocate available resources in a manner which will provide treatment of those conditions constituting the most serious threats to the health of such medically indigent persons, as well as increase access to primary medical care to prevent deterioration of the health conditions among medically indigent people . . . . (Sec. 26-15-102 (1), C.R.S.).

On the other hand, under the section that discusses requirements to be included in provider contracts, statutes state that:

> Contract dollars provided over the fiscal year will be managed to assure that funds are available to provide emergency services as defined in this article . . . . Every provider awarded a contract pursuant to this section shall prioritize for each fiscal year the medical services which it will be able to render. . . . Such medical services shall be prioritized in the following order: emergency care for the full year; any additional [urgent] medical care for those conditions the state department determines to be the most

> serious threat to the health of medically indigent persons; [and] any other additional medical care. (Sec. 26-15-106 (8, 9), C.R.S.).

Emergency care is defined as "treatment for conditions of an acute, severe nature which are life, limb, or disability threats requiring immediate attention, where any delay in treatment would, in the judgment of the responsible physician, threaten life or loss of function of a patient or viable fetus" (Sec. 26-15-103 (1), C.R.S.).

Clinics are outpatient facilities and most are not designed to provide emergency care, and, in addition, some do not provide urgent care. Our review of CICP data for Fiscal Year 2001 indicates that 9 out of the 18 clinics that were CICP providers during the year did not furnish any emergency or urgent care services. Thus, funding clinics with CICP monies appears to be at variance with statutory priorities established under Section 106.

However, the role of the clinics as CICP providers has long been recognized by the State, as demonstrated by continued appropriations clearly designated as going in part to the clinics. In fact, the Fiscal Year 2002 appropriation for CICP clinics is in a separate Long Bill line item from all other CICP providers. The clinics furnish primary care to uninsured low-income individuals who do not qualify for other government programs. Hence, they play a critical role in meeting the second aspect of CICP's intent: to increase access to primary medical care for the medically indigent. According to the National Association of Community Health Centers, which represents clinics that are federally qualified health centers, several studies indicate that increased access to primary care can improve health status and lessen the need for more costly hospital care.

Thus, the clinics fulfill an important part of the intent of CICP, although they do not meet the medical services priorities in the manner outlined under Section 106. This also points to one of the basic contradictions of the Colorado Indigent Care Program statutes: most charges for which providers receive partial reimbursement under the program are emergency or urgent care charges, despite the fact that primary care has been shown to be more cost-effective over the long run. In Fiscal Year 2001 almost $206.4 million (61 percent) in CICP charges were submitted for emergency and urgent care, while about $130 million (39 percent) were submitted for non-urgent services, or primary care. Obviously, emergency and urgent care needs must continue to be addressed. However, in order to continue to promote access to primary care, the Department should seek statutory change to clarify the role of clinics that do not provide emergency and/or urgent care services in the Colorado Indigent Care Program.

Reimbursement Payments in Excess of CICP Costs

The second significant discrepancy concerns whether or not it is consistent with the program's intent that CICP providers receive CICP payments that, in total, are greater than their CICP costs. According to statutes:

> Contracts with providers shall specify the aggregate level of funding which will be available for the care of the medically indigent. However, providers will not be funded at a level exceeding actual costs (Sec. 26-15-106(6)(a), C.R.S.).

The Department no longer specifies the level of funding in contracts but instead uses more general language; this itself is not a concern. However, it is not clear that it is consistent with the intent of statutes to reimburse some providers for over 100 percent of their CICP costs, which occurs in some instances when bad debt payments are included. As illustrated earlier in Table 7, in Fiscal Year 2001 private hospitals under Component 1A received average reimbursement rates of 138.4 percent of their CICP costs, after the inclusion of bad debt payments (see Appendix B for breakdown by individual hospitals). We recognize that bad debt payments are calculated on a basis other than CICP costs and that bad debt is itself an uncompensated cost. However, we question whether it is appropriate to reimburse some providers in excess of their CICP costs—by means of additional payments against their bad debt—when other providers receive only 27 percent reimbursement of their CICP costs and do not qualify for any bad debt payments. The Department should seek clarification regarding the intent of CICP payments in relation to CICP costs.

Other Discrepancies

Additional discrepancies between statutes and operations that are less fundamental are listed in Table 8. Many of these provisions appear to be obsolete and may need to be reassessed.

Table 8: Colorado Indigent Care Program
Statutory Provisions Needing Review
Based on 2001 Colorado Revised Statutes

Cite	Text	Problem
Sec. 26-15-104.3	As a condition of eligibility for services . . . a legal immigrant shall agree to refrain from executing an affidavit of support for the purpose of sponsoring an alien on or after July 1, 1997	No enforcement provisions in law or regulation.
Sec. 26-15-105(1)	The [annual] report shall include recommendations regarding the following . . . Feasibility of . . . a medically needy option. . . . A schedule for implementation of a statewide service delivery plan to commence July 1, 1992	The annual report does not address these areas, and requirements may be obsolete.
Sec. 26-15-106(5.5)	Denver health and hospitals shall provide to the joint budget committee and the chairmen of the senate and house health, environment, welfare, and institutions committees a final report provided by any management companies . . . under contract with Denver health and hospitals for the management of Denver general hospital.	Obsolete (Denver General Hospital has been restructured as part of Denver Health and Hospital Authority).
Sec. 26-15-106(12)	The state department shall establish patient per diem standards for comparable care to be effective July 1, 1984.	Obsolete; the program does not reimburse providers on the basis of patient per diems.
Sec. 26-15-106(15)	Providers . . . shall, no less than quarterly, reimburse one another for the cost of emergency medical care rendered to residents of one another's respective regions, as well as any nonemergency care which the responsible provider approved in advance.	Inconsistent with providers' current practice. Providers do not reimburse each other for care.

Source: Office of the State Auditor analysis of program statutes, Department of Health Care Policy and Financing data, and other information.

Statutes should provide clear guidance concerning how state programs such as CICP are to be operated. Inconsistencies between state law and program operations should be reconciled to avoid noncompliance or misunderstanding about the program's basic intent or requirements. The Department should seek statutory change as necessary in order to ensure that the program operates in accordance with legislative intent and that statutes reflect current conditions.

Recommendation No. 2:

The Department of Health Care Policy and Financing should seek legislative change to clarify the intent of and requirements for the Colorado Indigent Care Program including:

a. The role of clinics in providing primary care in relation to requirements in statute establishing medical services priorities under the program.

b. Prohibitions against reimbursements that exceed CICP costs in cases where providers receive other program payments, such as those for bad debt.

c. Statutory requirements that are obsolete or need to be reassessed.

Department of Health Care Policy and Financing Response:

Agree. The Department will examine opportunities for seeking legislative change to clarify the intent of and requirements for this program. The earliest the Department would expect any legislative action would be the 2003 session of the General Assembly.

CICP and Other State Health Programs

The Colorado Indigent Care Program is one of several state programs that provide health care to indigent individuals. The Medicaid program and the Children's Basic Health Plan (CBHP) also serve this population, and the Department of Health Care Policy and Financing oversees all three programs. Working in conjunction with one another, these three programs fund health care services for individuals with financial resources at or below 185 percent of the federal poverty level ($32,653 for a family of four as of April 2001). In Fiscal Year 2001:

- The Medicaid program expended about $1.4 billion in payments for medical services, excluding mental health and developmental disabilities, and had an average monthly enrollment of 295,345.

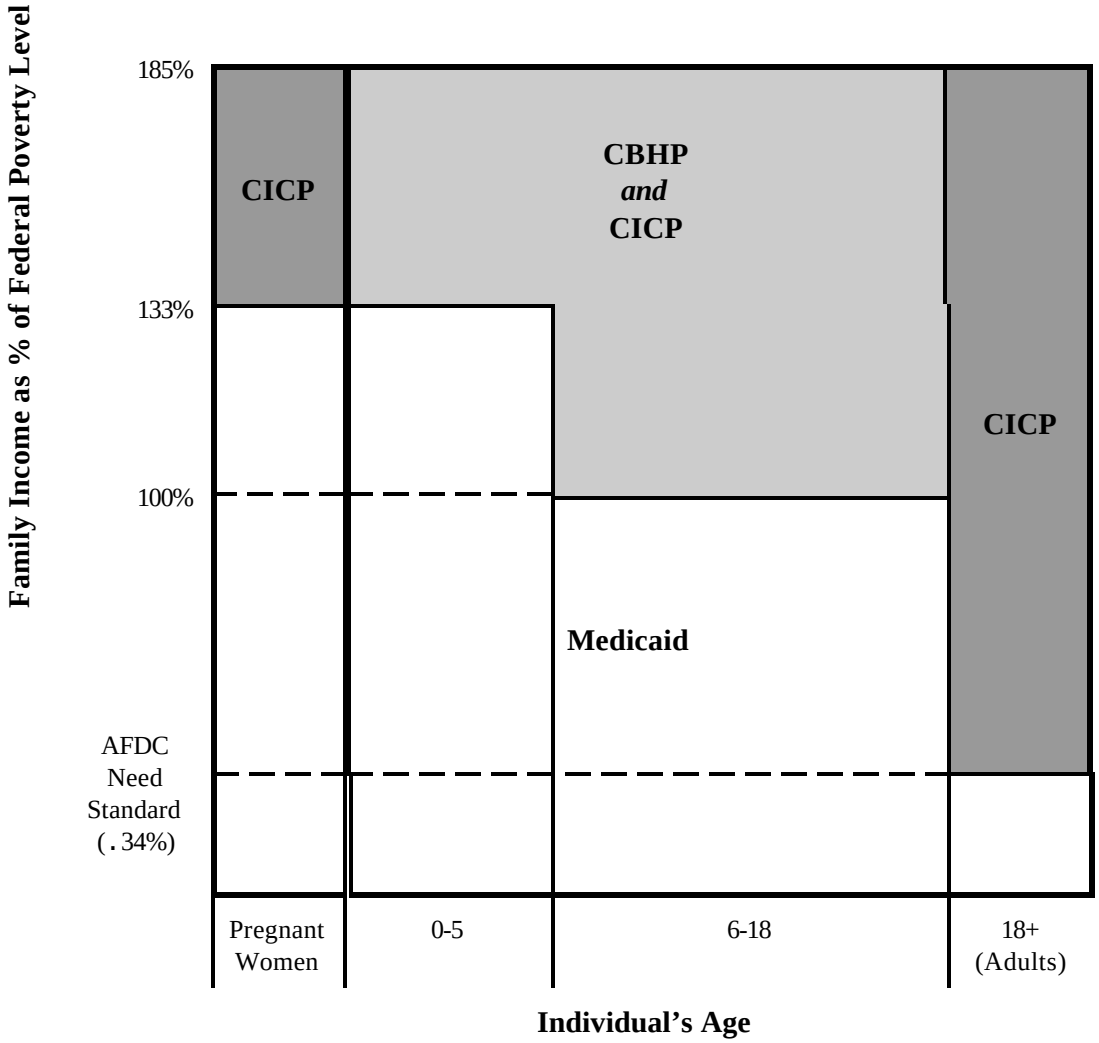
- The Children's Basic Health Plan expended about $45.5 million and had an average monthly enrollment of 29,513.

- The Colorado Indigent Care Program reimbursed providers for $131.9 million to partially fund services to approximately 160,100 individuals.

While all three programs target roughly the same population, there are important differences among the programs, ranging from financing mechanisms to beneficiary eligibility requirements. From a budgetary perspective, the most important distinction is that the Medicaid program is an entitlement under federal law. This means that the program must serve all individuals who meet the program's eligibility rules. CICP and CBHP are not entitlement programs, and therefore, the State can limit expenditures as necessary. Another important distinction is that, unlike the Medicaid program and CBHP, CICP is not an insurance plan with established benefits and a roster of beneficiaries. All three programs are funded by substantial amounts of federal funds.

Table 9 offers a simplified graphic representation of the eligibility differences between the three programs. As can be seen, when an individual's age increases, the maximum income allowable under the Medicaid program decreases. Young children are eligible for Medicaid if their family's income is less than 133 percent of the federal poverty level (FPL); however, when a child turns six, the family income cannot exceed 100 percent FPL. Additionally, with the exception of elderly persons and persons with disabilities, for an adult to qualify for Medicaid, he or she must be a parent or guardian of a Medicaid-eligible child. Individuals who are not eligible for Medicaid may be eligible for CBHP or CICP. It should be noted that this table does not show the impact on eligibility of asset tests for Medicaid and CICP or of the differing definitions of income among programs.

Table 9: State-Subsidized Health Insurance and Health Care Services
Colorado Indigent Care Program (CICP), Children's Basic Health Plan (CBHP), and the Medicaid Program
Fiscal Year 2002
(Table does not reflect the impact on eligibility of asset tests for CICP and Medicaid or of differing program definitions for income.)



Source: Office of the State Auditor analysis of Department of Health Care Policy and Financing data.

With all three programs serving similar populations, combined with the fact that individuals can experience changes in their financial or family situations that affect their program eligibility, there is the risk that individuals may be served in a program other than the one intended by state policy. This is exacerbated by the fact that eligibility is determined by different entities for all three programs.

The State is in the process of developing the Colorado Benefits Management System (CBMS), which is intended to be an eligibility system for the Medicaid program, CBHP, and CICP, as well as numerous public assistance programs such as Temporary Assistance for Needy Families, Food Stamps, and the Old Age Pension program. In the case of the three health care programs, CBMS will verify that an individual is not eligible for Medicaid or CBHP prior to enrolling the person in CICP. This should help ensure that individuals are enrolled in the correct program. CBMS was scheduled to be operational by July 2003; however, the Department reports that recent discussions indicate implementation may be delayed.

Our audit examined data to determine what types of overlap currently exist between the Medicaid program and CICP in terms of persons enrolled in Medicaid receiving services paid for under CICP. We found evidence of problems, some of which would presumably be addressed by CBMS in the future. However, we also found problems with retroactive adjustments that CBMS is not likely to address. HCPF should improve the eligibility process for CICP and implement better controls in this area to better ensure that retroactive adjustments occur.

We also assessed the Department's progress in moving eligible children from CICP into CBHP. This movement has been a priority for the State because of the superior health benefits, provider reimbursement, and higher federal matching rate under CBHP as opposed to CICP. Data suggest that progress has been made in this effort.

Medicaid and the Colorado Indigent Care Program

In order to determine what types of overlap might exist between the Medicaid program and CICP, we examined a sample of CICP charges to determine if participating providers were submitting charges to CICP for individuals who were simultaneously enrolled in the Medicaid program. As our sample, we selected CICP charges for services rendered in April 2000. Using social security numbers, we compared the list of individuals receiving these CICP services with Medicaid eligibility information for April 2000 maintained by HCPF.

We identified about 1,600 unique individuals who were enrolled in Medicaid on the same date as they received services that were charged to CICP. The total amount of CICP charges for these individuals was about $2.3 million, and we estimate that providers would have been reimbursed about $554,800 on the basis of these charges. Our results are summarized in Table 10 below.

Table 10: Colorado Indigent Care Program
CICP Charges and Estimated Reimbursement Amounts[1]
for Medicaid-Eligible Individuals[2]
April 2000

CICP Provider Category	CICP Charges for Medicaid-Eligible Individuals	Estimated CICP Costs	Estimated CICP Reimbursement
Component 1A Hospitals	$1,581,392	$1,092,689	$487,485
Outstate Hospitals	$687,301	$206,396	$49,535
Outstate Clinics	$83,740	$73,953	$17,749
Totals	**$2,352,433**	**$1,373,038**	**$554,769**

Source: Office of the State Auditor analysis of Department of Health Care Policy and Financing data.

[1] Providers are reimbursed using a formula that converts CICP charges to the estimated costs associated with those charges. These costs are then multiplied by a reimbursement rate that is determined annually. Reimbursement rates can vary significantly among categories of providers.

[2] Data on Medicaid eligibility was provided by the Department and based on information in the Client-Oriented Eligibility Network (COIN).

In analyzing these results, we found that in many cases (48 percent) the individual had been determined Medicaid-eligible at least three months, and sometimes years, prior to receiving CICP services in April 2000. In the remaining cases (52 percent), the individual had been determined Medicaid-eligible within three months prior to receiving CICP services in April 2000. Specifically, out of the 1,622 CICP individuals we identified that were Medicaid-eligible at the time they received CICP services:

- 783 individuals (48 percent) were determined eligible for Medicaid as of January 1, 2000, or earlier—in other words, at least three months before April 2000. Of these, 336 had been eligible for Medicaid for a full year prior to April 2000. One client had been Medicaid-eligible since March 1988.

- 544 individuals (34 percent) had become Medicaid-eligible between January 1, 2000, and March 31, 2000.

- 295 (18 percent) of these individuals became Medicaid-eligible during April 2000, or the same month in which they received CICP services.

Reasons for Overlaps Between CICP and Medicaid

Medicaid-eligibility screening. Because 783 of the overlaps occurred in cases in which individuals had been eligible for Medicaid for a number of months, this indicates that the providers are not effectively screening individuals for Medicaid prior to designating them as eligible for CICP. This is disturbing for both providers and patients because providers receive better reimbursement under Medicaid and individuals receive better benefits and pay lower copayments. In addition, it is not in the State's best interest for Medicaid individuals to be served under CICP, because the federal funds that are used to finance CICP are limited. Further, the majority of Medicaid recipients are enrolled in some type of managed care, which means that the State pays a monthly capitation payment intended to pay for some or most of the services an individual receives. If the State is also paying for services for these individuals through CICP, the State is, in effect, paying for the same service twice.

To address eligibility determination problems, HCPF should work to improve Medicaid screening during the CICP eligibility determination process by emphasizing screening procedures during the eligibility training workshops for providers. This will help ensure that providers adequately check for Medicaid eligibility. For example, all of these providers are Medicaid providers and can call the State's Medicaid fiscal agent in order to find out if an individual is already on Medicaid.

Retroactive adjustments. For the remaining 839 cases in which Medicaid eligibility was determined three months prior to April 2000, or in April 2000, there are timing issues (e.g., 90-day retroactive Medicaid-eligibility for an individual) that could explain why a provider might submit CICP charges for a client who is currently listed as being Medicaid-eligible for the same time period. Our analysis did not cover a sufficient period of time to determine how many of the seemingly erroneous charges to CICP might have been subsequently reversed by providers. However, we found that the Department lacks clear procedures and good information about whether or not providers are making these retroactive adjustments in cases where individuals were classified as CICP-eligible and later determined to be Medicaid-eligible. Under state law, only county departments of social services can determine Medicaid eligibility. Therefore, providers can only screen for Medicaid and must refer patients to the counties for the formal determination if the provider believes that the person qualifies for Medicaid.

Similarly, a person may have a Medicaid application pending with the county at the time he or she needs services. In these cases, the provider cannot classify the person as Medicaid-eligible, regardless of how likely it may appear. However, providers can determine CICP eligibility, and, therefore, if the person's Medicaid status is unclear and the individual meets CICP requirements, the charge is classified as a CICP charge. If a

person is later determined by the county to be eligible for Medicaid, under Medicaid regulations any services incurred up to 90 days prior to the date of eligibility determination may be covered by Medicaid. This requires that the provider reclassify the CICP charge as a Medicaid charge.

The Department depends on providers to perform the appropriate reclassifications for these CICP charges. As mentioned above, our analysis did not cover a sufficient period of time to allow us to assess whether or not these adjustments had taken place. However, we found that the CICP manual does not give providers clear instructions on how these adjustments should be reported. These procedures are documented in the section with the provider audit guidelines and not in any section that outlines procedures for providers themselves. The Department reports that it receives some letters from providers regarding refunds to CICP based on later adjustments.

Without clear instructions to providers regarding how post-year-end adjustments should be tracked and reported, the Department lacks assurance that it receives all refunds due to CICP or that these adjustments are handled appropriately. For example, the Department reports that one provider deletes a sufficient number of CICP charges from the current fiscal year to offset the amount of retroactive Medicaid adjustments for prior year CICP clients. This may result in charging the correct net amount to CICP. However, it means that utilization numbers for CICP services may not be accurate and that the Department lacks knowledge of whether any adjustments were made.

The Department should take steps to prevent improper billing to CICP and to improve post-year-end reporting. Our results further emphasize the need for adequate review and follow-up with providers on CICP eligibility problems that are identified during the annual provider audits, as described in Chapter 3.

Recommendation No. 3:

The Department of Health Care Policy and Financing should follow up on the results of the data match performed by the Office of the State Auditor between the Colorado Indigent Care Program and the Medicaid program. HCPF should contact providers, as appropriate, that submitted CICP claims for individuals who are eligible for Medicaid and request that providers report on how adjustments to CICP charges have been made for these claims. It should seek reimbursement as appropriate.

Department of Health Care Policy and Financing Response:

Partially agree. The Department notes that there is not evidence that a duplicate claim was filed with both the Medicaid program and CICP. The Department does not plan to contact providers regarding the finding of the Office of the State Auditor, due to limitations of the sample size. However, the Department will work toward identifying the scope of the issue and will take steps to both clarify policy and, to the extent possible, eliminate or minimize the problem in the future. The Department will clarify language in the Fiscal Year 2002-2003 CICP Manual that outlines procedures and policy in an attempt to minimize this problem in the future by July 1, 2002.

Auditor's Addendum

Our audit identified instances of possible overpayments to CICP providers for individuals that were eligible for Medicaid at the time CICP services were rendered. The detailed results of our data match are being provided to HCPF. Addressing known problems is essential for program integrity, and in this case, can be accomplished by distributing information from the data match to the providers for their review and follow up.

Recommendation No. 4:

The Department of Health Care Policy and Financing should ensure that applicants for the Colorado Indigent Care Program are screened for Medicaid eligibility in all appropriate instances by training providers on Medicaid eligibility screening procedures outlined in the CICP manual.

Department of Health Care Policy and Financing Response:

Agree. The Department will strengthen the CICP eligibility training and include further training on the Medicaid eligibility screening procedures that are already outlined in the CICP manual. This material will be included in the CICP eligibility training by July 1, 2002.

Recommendation No. 5:

The Department of Health Care Policy and Financing should ensure post-year-end retroactive adjustments are made to charges for the Colorado Indigent Care Program by

developing and implementing procedures for providers to report these adjustments and related information to the program.

Department of Health Care Policy and Financing Response:

Agree. The Department has already taken steps to clarify the guidelines outlined in the current CICP manual so all providers are aware of the procedures to report retroactive adjustments. These procedures will be included in the Fiscal Year 2002-2003 CICP Manual. The Department will implement the procedures for making adjustment by October 31, 2002, so the information will be included with the final Fiscal Year 2001-2002 cost data submitted by CICP providers.

Children's Basic Health Plan and the Colorado Indigent Care Program

For many years, low-income children not eligible for Medicaid could receive state-subsidized health care services only through CICP. However, with the creation of the Children's Basic Health Plan (CBHP) in April 1998, the State now has a third program targeted exclusively at children with a family income that does not exceed 185 percent of the federal poverty level. As a result, under current program rules low-income children are frequently eligible for both CICP and CBHP.

There are several advantages to enrolling children in CBHP rather than CICP. CBHP offers children a comprehensive set of benefits and greater access to providers than CICP. Families with children in CBHP pay lower copayments than under CICP and are better protected from catastrophic medical expenses related to their children. Providers receive higher reimbursement for care under CBHP, and increasing enrollment in CBHP improves CBHP's purchasing power for health care services. Finally, serving children through CBHP increases the financial resources available to CICP's other beneficiaries, such as single, nonelderly low-income adults that cannot be served in either CBHP or the Medicaid program.

In recognition of the advantages of serving children in CBHP rather than CICP, the General Assembly passed SB 00-223, which required that HCPF evaluate the possibility of eliminating CICP for children eligible for CBHP and requiring families to enroll these children in CBHP. The Department submitted the required report in November 2000. In the *Children's Basic Health Plan Performance Audit* (July 2000, Report No. 1225A),

conducted by the Office of the State Auditor, we recommended that the Department improve coordination between CBHP and CICP as part of an effort to facilitate this movement of children into CBHP and to promote overall program coordination and consolidation between these two programs and the Medicaid program.

Moving Children From CICP Into CBHP

During our current audit of CICP, we met with HCPF staff and reviewed program data to assess how successful the Department has been in coordinating CBHP and CICP and moving eligible children from CICP to CBHP.

Department staff described the following actions taken since our July 2000 audit to advance the transition of children from CICP to CBHP:

- Senate Bill 01-052 replaced CBHP's monthly premium structure with an annual enrollment fee. This change significantly reduced the cost of CBHP for families with an annual income greater than 100 percent of the federal poverty level by eliminating monthly premiums and instead requiring a much lower annual fee.

- During Fiscal Year 2001, state rules defining "family" under CBHP were changed in order to align the definition with that used under CICP. This was intended to facilitate the transition for families from CICP to CBHP and allow the Department to better coordinate the health care needs of family members, both children and adults.

- Department staff met with providers, many of whom are providers under both CBHP and CICP, to encourage them to recommend CBHP to families who have a choice between the two programs. Staff report that providers have been responsive and are actively supporting CBHP as the more beneficial option for families.

- Finally, the Department successfully proposed a rule change to the Medical Services Board for CICP that prohibits children eligible for CBHP from enrolling in CICP. This rule goes into effect on July 1, 2002.

To determine the impact of these efforts on enrollment, we compared information from the two programs. Because the programs track different types of data, our results are shown in two different tables. Table 11 illustrates the change in utilization of services by children under CICP from Fiscal Years 1998 through 2001. Table 12 shows the change in average monthly enrollment of children in CBHP between Fiscal Years 1999 and 2001. As can be seen, utilization of services by children in CICP has decreased about 52 percent

over the four-year period; this is likely a good indicator that fewer children are participating in CICP. CBHP began operations in April 1998, and Table 12 shows that average monthly enrollment for that program has increased about 130 percent during the three-year period shown. Therefore, the Department appears to have had success in moving children from CICP and into CBHP.

Table 11: Colorado Indigent Care Program
Number of Children Served
Fiscal Years 1998 Through 2001

	Fiscal Year			
	1998	**1999**	**2000**	**2001**
Inpatient admissions and outpatient visits for children 0-17 years of age	90,572	62,045	45,063	43,617

Source: Office of the State Auditor analysis of Department of Health Care Policy and Financing data.

Table 12: Colorado Indigent Care Program
Children Served Through the Children's Basic Health Plan
Fiscal Years 1999 Through 2001

	Fiscal Year		
	1999	**2000**	**2001**
Average monthly enrollment (0-18 years of age)	12,825	23,015	29,513

Source: Office of the State Auditor analysis of Department of Health Care Policy and Financing data.

Continued Need for CICP for Children

Although the Department has been successful in moving many children from CICP to CBHP, it is evident that a number of low-income children still rely on CICP for reduced-cost health care. Although it is not known how many children are still served in CICP that are eligible for CBHP, there are reasons why there will always be a need for some low-income children to receive services through CICP.

Primarily, not all children in families with income of less than 185 percent FPL are eligible for CBHP. Federal law prohibits a child from enrolling in CBHP if the child is eligible for health coverage under a state health plan because a family member is employed by a public agency in the State of Colorado. Also prohibited from enrollment in CBHP are children who are legal immigrants but entered the country after August 22, 1996, and have not lived

in the United States for at least five years. There are also state statutes and regulations that bar children from enrollment in CBHP. For example, CBHP rules prohibit enrollment by a child who has, or has had within the past three months, coverage through an employer-sponsored health plan unless the child lost health coverage due to a change in or loss of employment. Finally, there are other circumstances in which a child may be eligible for CICP but not for CBHP. For example, CICP allows seasonal workers to average their seasonal income over the year so that the family is equally eligible in high- and low-income months. CBHP does not allow this.

By continuing to involve providers in encouraging families to enroll children in CBHP, rather than CICP, and by implementing the new rule requiring CBHP-eligible children to be enrolled in that program, the State should be able to minimize the number of children served in CICP to the extent possible under state and federal laws and regulations.

Provider Reimbursement

Chapter 2

Introduction

In Fiscal Year 2001 the Colorado Indigent Care Program paid participating providers about $131.9 million as partial compensation for the cost of providing care to low-income individuals eligible for CICP. There were 66 providers in the program, including 17 clinics in the Outstate clinic category, 40 hospitals in the Outstate hospital category, and 9 hospitals in the Component 1A category. In total, these providers submitted over $382 million in CICP charges. These charges are the primary basis upon which the Department determines payments to providers.

Calculating Payments to Providers

Our audit examined the Department's policies and procedures for making payments to CICP providers. Our objectives were to determine if the Department's payments were calculated accurately and on an equitable and appropriate basis for all providers within each category (Outstate clinics, Outstate hospitals, and Component 1A hospitals). As mentioned, payments to CICP providers are primarily made on the basis of CICP charges and estimated costs; in Fiscal Year 2001 about $89.3 million (68 percent) of the $131.9 million in payments to CICP providers were calculated on this basis. The remaining $42.6 million was composed of $21.2 million in additional payments under the Major Teaching Hospital program and $21.4 million in bad debt payments. Because the majority of payments are based on CICP costs derived from CICP charges, and because the calculations required for these payments are more complex, our audit focused on the payments the Department calculates using CICP charges. We performed a limited review of Major Teaching Hospital and bad debt payments, which do not involve as much data collection and calculations. We did not identify problems with respect to the Major Teaching Hospital and bad debt payments.

Our audit tested providers' prospective payment amounts for Fiscal Year 2002. We examined the Fiscal Year 2000 provider data that served as the basis for Fiscal Year 2002 payment calculations and the Department's process of compiling and reviewing the data; we tested a sample of charges from both Denver Health Medical Center (Denver Health)

and the University of Colorado Hospital (University Hospital) and verified the charges against supporting documentation; we tested the Department's process for calculating payments to providers; and we evaluated the Department's methods and processes for accuracy, equitable treatment of providers, and adherence to state and federal requirements.

We found that the Department needs to improve controls over the reimbursement process by (1) issuing policies that define the charges and related adjustments that are to be submitted to HCPF for CICP, (2) ensuring charges are supported and allowable under state policy, and (3) implementing procedures to adequately document and review payment calculations and related decisions. Finally, the last section of this chapter recommends a change in one aspect of the method used to calculate payments for Component 1A providers in order to streamline the calculation and achieve a more equitable basis for determining estimated CICP costs for these providers. As a background to the findings, the calculations used to arrive at CICP costs and providers' reimbursements are described below.

In order to determine CICP *costs*, the Department must compile information on CICP *charges* and then, using a cost-to-charge ratio, calculate the estimated CICP costs of those charges. Charges are those amounts that providers bill for the services they render to CICP-eligible individuals. Because of the time it takes to compile CICP charges from all providers at the end of the fiscal year, the Department calculates the current year's reimbursements on the basis of actual CICP charges from two years prior. For example, the reimbursement payments for Fiscal Year 2002 are based on providers' CICP charges submitted for Fiscal Year 2000 and the related estimated costs of those charges. These calculations are outlined below.

Calculation of CICP Write-Off Costs and Provider Payments

1. Total CICP Charges - (Third Party Payments + Patient Liability) = Write-Off Charges
2. Write-Off Charges × (Medicare Costs[1] /Medicare Charges[1]) = Write-Off Costs
3. Write-Off Costs × Two-Year Inflation Factor = Estimated Write-Off Costs
4. Estimated Write-Off Costs × Reimbursement Rate = Projected Payment for Year

[1]Medicare costs and Medicare charges are the provider's total allowable costs and charges under the Medicare program from Worksheet C of the provider's Medicare cost report.

To calculate each provider's payment, total CICP charges are first reduced by payments from third party payers (payments from other insurance plans, if the individual has other coverage) and the patient's liability (i.e., copayment) to arrive at write-off charges. Second, write-off charges are multiplied by a ratio based on total allowable Medicare costs and charges (referred to as a provider's "cost-to-charge ratio") from the provider's most recent Medicare cost report; this calculation yields the provider's estimated cost of serving CICP clients. Third, write-off costs are inflated two years ahead to compensate for the two-year time lag between the base year (the year in which the charges occurred) and the year for which reimbursements are being calculated. Lastly, the inflated estimated costs are multiplied by the reimbursement rate for the provider's category to arrive at the provider's projected payments for the fiscal year. For example, for Fiscal Year 2002 these rates are Outstate clinic, 28.8 percent; Outstate hospital, 28.8 percent; and Component 1A hospital, 85.3 percent. Steps 1 through 4 are calculated for each individual provider using that provider's data.

Providers are notified at the beginning of the fiscal year of the amount of their projected payments for the period, and payments are sent to providers approximately every two months. As of Fiscal Year 2002, all providers will be paid on a "prospective" basis. This means the payments will not be adjusted at year-end for the difference between the provider's "estimated costs" and "actual costs" for the year. Prior to this time, payments to Outstate hospitals and clinics were adjusted to actual costs at the end of each fiscal year. Component 1A hospitals have been paid under the prospective method for CICP for a number of years.

Clarification of Policies on Charges to Be Submitted to CICP

In order to determine the accuracy of the projected amounts for provider payments for Fiscal Year 2002, we reviewed the charges submitted to the Department for Fiscal Year 2000 because, as stated above, under the Department's methodology these were the charges upon which the Fiscal Year 2002 reimbursements are based. Our audit tested a sample of 25 charges each from University Hospital and Denver Health to determine if the charges were for CICP allowable services and provided to eligible individuals. In addition, we tested whether the information submitted to HCPF for the charges was consistent with the underlying data maintained by the provider. These two providers render the highest volume of services under CICP and receive the highest dollar amount of payments. For example, in Fiscal Year 2001 they received payments of $61.8 million on the basis of the CICP charges they submitted to HCPF for Fiscal Year 1999. This accounted for over 69 percent of all CICP payments in Fiscal Year 2001 that were made on the basis of CICP charges.

Out of the 25 Fiscal Year 2000 charges we examined for each of these providers, we found errors in 10 of the charges (40 percent) at Denver Health and 5 of the charges (20 percent) at University Hospital. Generally, the errors related to eligibility documentation and incorrect copayments. Since Fiscal Year 2000, Denver Health reports that it has improved its ability to locate eligibility documentation by implementing a new system that scans applications directly into the system. Additionally, Denver Health has instituted a quality review process to reduce errors related to copayments. The errors we identified at both providers were generally consistent with the results of the annual CICP provider audits and indicate the need for the Department to have an effective audit process for CICP. (The provider audits and the Department's oversight of the audits are discussed further in Chapter 3.)

Inconsistencies in Calculating Write-Off Charges

The issue identified that was of greatest concern, however, and which was not identified during the annual provider audits, was that the two providers included different amounts in third party payments. Due to their differing interpretations of what was allowable under state and federal laws and regulations, the two providers calculated third party payments differently and reported this information, along with CICP charges, to the Department. This caused a lack of consistency in how write-off charges were calculated for the providers, and, as a result, these providers' payments were calculated using inconsistent data.

The discrepancy stemmed from instances in which an individual was eligible for both Medicare and CICP. Of the 25 charges tested at University Hospital, we identified 3 charges (12 percent) for which University Hospital did not include the Medicare contractual adjustment in third party payments when reporting CICP charges to HCPF. The Medicare contractual adjustment is the difference between the hospital's normal charge for a service and the amount that the federal government has agreed under the Medicare program to pay for the service; in other words, the contractual adjustment is a discount on services that the provider agrees to furnish in order to participate in Medicare. Because the Medicare contractual adjustments were not included in third party payments, the Department did not subtract these adjustments from total charges when calculating write-off charges. In effect, University Hospital billed CICP for the discount it is required to give when providing services under the Medicare program.

University Hospital stated that it has routinely charged the Medicare contractual adjustment to CICP because it represents "uncompensated charges," and the State does not have policies in place prohibiting this practice. However, under federal Medicare regulations, Medicare providers are not allowed to bill individuals or other programs, including CICP, for the Medicare contractual adjustment. During our review of Denver Health charges, we

found that Denver Health had included the Medicare contractual adjustment with third party payments, and thus, the contractual adjustment was not billed to CICP. Denver Health stated that it was not its policy to bill CICP for the Medicare contractual adjustment.

Upon request, University Hospital reported to us that its Fiscal Year 2000 CICP charges included approximately $6.7 million in Medicare contractual adjustments. Using the Department's method for calculating payments to Component 1A providers, we estimate that this translates into about $2 million (9 percent) of University Hospital's total projected Fiscal Year 2002 reimbursement of $21.7 million in Component 1A payments. (University Hospital's reimbursement calculation is discussed later in this chapter in Recommendation Nos. 10 and 11.) In other words, University Hospital's reimbursement would have been $2 million less for the current year, had the Medicare contractual adjustments been reported as part of third party payments and subtracted out of total CICP charges. As a result, there was $2 million less available to pay other Component 1A providers.

The inconsistencies in reporting contractual adjustments means that providers are not being reimbursed on an equitable basis. In this particular case, the inconsistency is particularly problematic because it results from the provider's lack of compliance with federal regulations. Therefore, we are recommending that the Department adjust University Hospital's Fiscal Year 2002 projected reimbursement to deduct the $2 million derived from the Medicare contractual adjustments not subtracted from CICP charges. In addition, HCPF should work with the Centers for Medicare and Medicaid Services, the federal agency that oversees both of these programs, to determine additional actions that the Department might need to take with respect to prior year CICP payments to University Hospital.

Formalization of Policies and Use of On-Site Audits

The inconsistency in how the two largest CICP providers handled contractual adjustments occurred for two reasons. First, the Department does not audit charges submitted to the program to the provider's supporting documentation. Hence, HCPF did not have sufficient means to identify this problem and address it. Currently the Department relies on audits performed by providers' external auditors to identify problems related to CICP; as mentioned earlier, the audits are discussed in Chapter 3. Additionally, since the provider audits did not identify the problem with Medicare contractual adjustments at University Hospital, there is no assurance that other providers are not billing the State for these adjustments as well.

The second reason for this inconsistency is that the Department has not formalized policies regarding how contractual adjustments should be reported to the State to ensure that they

are subtracted from total CICP charges. More broadly, the CICP manual does not define "charges." The manual should state that charges should be derived from the provider's billing system and that charges for CICP services should be the same as those charged to other patients receiving the same service during the same period. Although we did not find instances in which providers were billing CICP clients for charges on a basis different from that used for other patients, the problems identified with the contractual adjustments demonstrate the potential for inconsistencies in reporting—and, thus, the basis for reimbursement—when terms and requirements are not clearly defined.

Program staff report that it is the Department's intention that contractual adjustments be included in third party payments. However, this has only been communicated informally, which clearly is not sufficient. The Department should establish policies regarding CICP charges and adjustments to charges and periodically perform on-site testing of charges for those providers that receive significant amounts of reimbursement under CICP, or where other indications of risk exist. While it is reasonable for the Department to use the external audits as one tool to oversee the program, the audits are not a sufficient substitute for the Department itself testing the source data used to determine payments for CICP. Finally, the next section describes the Department's increasing reliance on summary data from providers. This will present further risks and possible misapplication of state policies and further indicates the need for HCPF to undertake some degree of on-site testing of charges.

Recommendation No. 6:

The Department of Health Care Policy and Financing should reduce the projected Fiscal Year 2002 payment for University Hospital to reflect the provider's overbilling of the State related to the Medicare contractual adjustments of approximately $6.7 million. HCPF should work with the Centers for Medicare and Medicaid Services to determine additional actions the State should take as a result of prior overpayments made with Medicaid Disproportionate Share Hospital funds to University Hospital due to Medicare contractual adjustments.

Department of Health Care Policy and Financing Response:

Agree. The Department has requested the necessary data from University Hospital so these adjustments can be made to the figures reported in the Fiscal Year 1999-2000 and Fiscal Year 2000-2001 annual reports and the corresponding projected Fiscal Year 2001-2002 reimbursement will be adjusted.

Once this report has been published, the Department will contact the Centers for Medicare and Medicaid Services to determine any potential liability for the State. The Department expects this work to be finalized before July 1, 2002. The Fiscal Year 2002-2003 CICP Manual will further clarify that Medicare contractual adjustments cannot be billed to CICP.

Recommendation No. 7:

The Department of Health Care Policy and Financing should ensure charges submitted for the Colorado Indigent Care Program are consistent with the program's intent and reported on the same basis for all providers by:

a. Developing formal policies regarding the basis for reported charges and how contractual adjustments and other adjustments should be treated.

b. Performing periodic on-site testing of the validity of charges and related adjustments submitted to CICP on the basis of the amount of reimbursement a provider receives and other risk factors.

Department of Health Care Policy and Financing Response:

Agree. The Department will formalize the policies regarding contractual adjustments and other adjustments in the Fiscal Year 2002-2003 CICP Manual that will be issued by July 1, 2002. Currently the Department does not have the funding or the FTE available to perform periodic testing of the validity of charges and related adjustments submitted to CICP. The Department will consider requesting additional resources to perform this function.

Auditor's Addendum

If the decision ultimately is made to continue to reimburse CICP providers primarily on the basis of CICP costs derived from CICP charges (see Recommendation No. 1), the Department must implement controls to ensure the accuracy and appropriateness of those charges, including on-site audits performed on the basis of risk. Without these controls, requesting data on CICP services from providers is not a meaningful requirement.

Substantiation of Charges Reported to CICP

In addition to testing a sample of CICP charges submitted by Denver Health and University Hospital, we examined the CICP charge data submitted by providers in all three categories of CICP providers to ensure that the data agreed with the amounts used by HCPF as the basis for calculating reimbursements. During our review we found that Denver Health and University Hospital had submitted some CICP charge information to HCPF in summary format. When we requested that these providers furnish us with the supporting data for these summary amounts, we found these providers could not substantiate the full amount of charges reported for Fiscal Year 2000. Denver Health was not able to support about $245,800 (0.2 percent) of CICP charges submitted, and University Hospital was not able to support about $1 million (1.3 percent) of its CICP charges. Providers reported that they had not maintained all underlying data for CICP charges, once it was submitted to HCPF. In some instances, they were unable to re-create the data.

In addition, Denver Health discovered an error that had resulted in an overstatement of almost $2,996,000 in ambulance charges reported to HCPF in summary format only for Fiscal Year 2000. This caused an overstatement of Denver Health's Fiscal Year 2002 projected payment of about $1 million. One of University Hospital's subcontractors, University Physicians, Inc. (UPI), discovered that it had erroneously submitted about $2,163,700 in duplicate charges for Fiscal Year 2000. Of this amount, $1,973,900 was for physician charges submitted through University Hospital, and $189,800 was for physician charges submitted through Children's Hospital. Children's Hospital is another Component 1A provider for CICP. These duplicate charges submitted by UPI resulted in an overstatement of University Hospital's and Children's Hospital's Fiscal Year 2002 projected payments of about $592,000 and $95,000 respectively. In total, the errors identified in summary data submitted by Denver Health, University Health, and Children's Hospital, resulted in total projected overpayments for Fiscal Year 2002 of almost $1.7 million. If we had not requested this detailed data, these errors might have gone undetected. Table 13 summarizes the results of our testing related to substantiation of charges by Denver Health and University Hospital.

Table 13: Colorado Indigent Care Program
Charges Reported for Reimbursement by Denver Health and University Hospital
Fiscal Year 2000 Charges (Basis for Fiscal Year 2002 Provider Payments)

Charges	Denver Health	University Hospital
Charges Submitted for Reimbursement to CICP	$122,751,954	$81,643,806
Less: Charges Supported With Detailed Data[1]	$105,797,904	$59,628,952
Subtotal: Charges Reported in Summary Format Only, No Detail Provided	$16,954,050	$22,014,854
Less: Additional Charges Substantiated With Detailed Data During OSA audit	$16,708,233[2]	$20,966,483[3]
Final Amount of Charges Not Substantiated With Detailed Data	$245,817	$1,048,371[4]
Percent of Total Charges Not Substantiated With Detailed Data	0.2%	1.3%

Source: Office of the State Auditor analysis of Department of Health Care Policy and Financing and provider data.

1 Hospital facility charges only.

2 Denver Health submitted summary charges for subcontracted services for pharmacy, physician, ambulance, and laboratory processing. During the audit, Denver Health reported that in reviewing its Fiscal Year 2000 ambulance charges it determined these charges were erroneously overstated by $2,995,691.

3 University Hospital submitted summary charges for its pharmacy charges and for subcontracted services for University Physicians, Inc. (UPI). During the audit UPI reported that it erroneously submitted $1,973,927 in duplicate physician charges for Fiscal Year 2000.

4 University Hospital was unable to provide detailed data to substantiate the full amount of pharmacy charges of $5.2 million because two months of Fiscal Year 2000 data had been deleted from the hospital's system.

The lack of substantiating data is caused by the Department's failure to enforce standard contractual provisions with CICP providers. All state contracts contain language that the contractor "shall maintain complete files of all records, documents, communications, and other materials that pertain to operations . . . or the delivery of services" under the contract and for which payments are made. The contract also states that records are to be maintained and accessible to the State for five years from the end of the State's fiscal year and that subcontractors are bound to the requirements of the contract.

In practice, the Department has not enforced data maintenance requirements, and in addition, it has allowed both Denver Health and University Hospital to report only summary information in cases where the providers contracted for services such as physician, pharmacy, or ambulance services. For University Hospital, HCPF attached special provisions to the facility's Fiscal Year 2000 contract stating that summary

information only could be submitted for physician and pharmacy charges. HCPF staff report that when a provider contracts for services, the provider may not have access to the detailed information. Therefore, for these providers HCPF relies on a combination of detailed data (from the facility itself) and summary data (for contracted services). This practice of allowing summary data to be submitted presents a risk for the State. If detailed data are not furnished, the Department risks making payments of state and federal funds for charges that do not exist.

Maintenance of Records Requirements

In Fiscal Year 2001 the Department's policy on data submission changed to require that only the three providers with the highest level of utilization submit detailed charges for the facility (Denver Health, University Hospital, and Memorial Hospital in Colorado Springs). These providers are still allowed to submit summary data for contractual services. All other providers are required to submit only summary information for all charges. Under requirements imposed by the federal Health Insurance Portability and Accountability Act (HIPAA), the Department anticipates that in the future it may be limited to receiving summary information from all providers, regardless of level of utilization (see discussion on HIPAA in Chapter 3). Therefore, the Department's reliance on summary data could increase.

It is the Department's responsibility to ensure that all costs reimbursed by the State for CICP are valid. To accomplish this, HCPF should establish policies in the CICP manual that reflect record maintenance and retention requirements that are consistent with those in the Department's contracts with providers. HCPF's increased dependence on summary reporting by the providers is another reason the Department needs to implement procedures for on-site testing, as discussed in the previous recommendation.

By enforcing these contractual requirements, the Department will help ensure that payments are based on valid charges and that detailed information is available for review by external auditors and by the State.

Recommendation No. 8:

The Department of Health Care Policy and Financing should reduce the projected Fiscal Year 2002 payments for the Colorado Indigent Care Program to correct the following errors in Fiscal Year 2000 charges:

a. Overbilling of ambulance charges in the amount of $2,996,000 by Denver Health.

b. Duplicate physician charges by University Physicians, Inc., in the amount of $1,973,900 and $189,800, respectively, by University Hospital and Children's Hospital. In addition, HCPF should consider the need for prior year adjustments based on charges from University Physicians, Inc.

Department of Health Care Policy and Financing Response:

Agree. The Department has requested the necessary data from Denver Health and University Physicians, Inc., so these adjustments can be made to the figures reported in the Fiscal Year 1999-2000 and Fiscal Year 2000-2001 annual reports and the corresponding projected Fiscal Year 2001-2002 reimbursement will be adjusted. The Department expects this work to be finalized before July 1, 2002.

Recommendation No. 9:

The Department of Health Care Policy and Financing should ensure that charges and related adjustments submitted to the Colorado Indigent Care Program are appropriate by establishing policies and procedures that enforce contractual provisions requiring providers to maintain detailed data to substantiate all amounts reported to the State as a basis for reimbursement, including those for contractual services.

Department of Health Care Policy and Financing Response:

Agree. The Department will further educate providers on the contents of the current contract and reinforce that providers maintain the detailed data to substantiate all amounts reported to the State as a basis for reimbursement, including those for contractual services, for a period of five years. The Fiscal Year 2002-2003 CICP Manual will clarify this issue. Implementation Date: July 1, 2002.

Review Process

As described, each provider's annual reimbursement is calculated using charges for CICP services and related adjustments. For Component 1A providers, the Department performs reimbursement calculations on the basis of data as reported in the CICP annual report. We investigated whether the CICP Fiscal Year 2000 annual report, which served as the basis for calculating Fiscal Year 2002 reimbursements for Component 1A providers,

accurately represents the uncompensated charges submitted by the two largest CICP providers, Denver Health and University Hospital. (Additional work performed on Component 1A and other providers' reimbursements is discussed in the next section.)

We identified three errors in the Fiscal Year 2000 CICP annual report in CICP data from University Hospital. Altogether, these errors resulted in a projected overstatement of that facility's reimbursement for Fiscal Year 2002 of $1.4 million. In this case, the errors were not caused by the data submitted by University Hospital; they were the result of errors made by HCPF staff when assembling the data, and they were exacerbated by the Department's method for calculating Component 1A payments.

As described previously, the Department subtracts from total charges the patient liability, or copayments, and any third party payments (payments from other insurers) received by the provider for each service. Currently the Department handles the "patient liability" part of the calculation differently for Component 1A provider reimbursements than it does for Outstate providers. For Component 1A providers, HCPF subtracts a provider-specific percentage of patient liability, rather than the full patient liability, from each provider's total charges (a more complete comparison of the calculations used for Component 1A and Outstate facilities is addressed later in this chapter). Staff explained that the percentage is intended to estimate the portion of patient liability the provider actually collects. The percentage varies by provider and is determined by the provider's past collections success. For Outstate providers, no such adjustment is made, and the full amount of patient liability is subtracted from total charges.

The errors identified with respect to University Hospital's reimbursement calculation are described below:

1. When HCPF staff compiled the Fiscal Year 2000 annual report, the amounts for third party payments and patient liability were transposed. The correct amount for third party payments of $6,737,031 was reported as patient liability.

2. In addition to transposing third party payments with patient liability, HCPF staff used the wrong number from University Hospital's data for patient liability. Instead of listing patient liability of $4,207,353, the Department erroneously used data from an earlier document that showed patient *payment* of $3,446,758.

3. The numbers for University Hospital in the CICP Fiscal Year 2000 annual report included charges of $2,121,159 from the Medication Assistance Program (MAP). MAP is a program by which pharmaceutical companies provide free medication to indigent patients. Since University was reimbursed fully by the companies for these charges, the amounts were not eligible for reimbursement under CICP.

Thus, the amount should not have been included in CICP charges or should have been included in both "total charges" and "third party payments" in order that the amounts would offset each other and there would be no effect on write-off charges. Instead, University Hospital reported the MAP charges in "total charges" and "patient liability."

Overall, the various errors and the Department's practice of reducing patient liability to an estimated patient payment amount resulted in an overstatement of $1.4 million in University Hospital's projected reimbursement for Fiscal Year 2002 of $23.1 million. The corrected amount is about $21.7 million.

Review of Provider Data and Annual Report Compilations

According to the Department, one staff person is solely responsible for compiling the CICP annual report, and no one confirms or reviews that each provider's charges, patient liability, and third party payments are correct and consistent with the provider's source data. Also, calculations using the information in the annual report are not reviewed.

Additionally, the staff person who calculates the Outstate provider reimbursements does not calculate the Component 1A provider reimbursements. Two different individuals calculate the Outstate and Component 1A provider reimbursements using slightly different methodologies, and the two staff members are not cross-trained to be knowledgeable about the other reimbursement calculation. With respect to the inclusion of the MAP charges in CICP charges, the error resulting from this could have been avoided if the Department had correctly identified that these were not CICP charges and excluded these charges, or by calculating reimbursements for Component 1A providers by using patient liability instead of estimated patient payments. Problems with the patient payment estimates for Component 1A providers are discussed in Recommendation No. 13 later in this chapter.

It is essential that reimbursements are accurately calculated in order to ensure providers are paid appropriately. The Department should have adequate procedures in place to ensure that the CICP annual report accurately represents each provider's charges, patient liability, and third party payments and that all calculations affecting reimbursements are performed correctly.

Recommendation No. 10:

The Department of Health Care Policy and Financing should correct the numbers for University Hospital in the CICP Fiscal Year 2000 annual report and make the necessary adjustments to Fiscal Year 2002 Component 1A reimbursements.

Department of Health Care Policy and Financing Response:

Agree. The Department has received the necessary data from University Hospital so these adjustments can be made to the figures reported in Fiscal Year 1999-2000, and the corresponding projected Fiscal Year 2001-2002 reimbursement will be adjusted. The Department expects this work to be finalized before July 1, 2002.

Recommendation No. 11:

The Department of Health Care Policy and Financing should develop and implement controls over provider data used in the reimbursement process by:

a. Establishing a formal review process for how provider data are compiled and presented in the annual report and used in reimbursement calculations.

b. Ensuring CICP staff are cross-trained in the provider reimbursement methodologies and review each other's work.

Department of Health Care Policy and Financing Response:

Agree. The Department has already implemented a review process for how provider data are compiled, presented in the annual report and used in the reimbursement calculations. Two staff members reviewed the data submitted by providers and confirmed the figures reported in the most recent annual report. Currently the Department does not have the funding or the FTE available to perform a formal review process or cross-train other staff members. The Department will consider submitting a request for additional resources to perform this function.

Auditor's Addendum

We emphasize that this recommendation addresses the need for adequate controls over calculating provider reimbursements. This is one of the Department's critical responsibilities for the program.

Documentation and Consistency of Reimbursement Methodology

In addition to testing providers' CICP charges and the accuracy of the information in the CICP annual report, we reviewed prospective payment calculations for 39 of the 68 CICP providers (57 percent) for Fiscal Year 2002. At the time of our review, these 39 providers were projected to receive almost $83.3 million out of the projected total of $86.7 million in Outstate and Component 1A payments for Fiscal Year 2002. Our sample included 8 Outstate clinics, 22 Outstate hospitals, and all 9 of the Component 1A hospitals.

From a technical viewpoint, we did not identify errors in the calculations of Fiscal Year 2002 payments. However, we identified inconsistencies in how HCPF calculated write-off costs for providers for Fiscal Year 2000. Because these cost data form the basis for calculating Fiscal Year 2002 payments, these inconsistencies have carried forward into current year payments. In addition, HCPF did not obtain documentation from providers to support critical information used in the Fiscal Year 2000 calculations; this could cause errors and lead to other inconsistencies' going undetected. These inconsistencies and lack of documentation create concerns that provider reimbursements are not being calculated on an equitable basis within each provider category.

Inconsistencies and Lack of Supporting Documentation

The Department arrives at provider payments by starting with each provider's charges for CICP services and subtracting third party payments and patient liability or copayments. The resulting write-off charges are multiplied by a cost-to-charge ratio:

Total Facility Costs/Total Facility Charges

By multiplying each provider's CICP write-off charges by the provider's cost-to-charge ratio, the Department converts CICP write-off *charges* to estimated CICP write-off *costs*. This ensures that the provider's CICP payments do not reflect any "profit" for the facility, since the State's intent is to reimburse on the basis of cost only. Cost-to-charge ratios for individual facilities can vary widely; in Fiscal Year 2001, individual hospitals' ratios of their total facility costs compared with total facility charges ranged from 0.31 to 0.98. Clinics that are federally qualified health centers (FQHCs) are mandated under federal regulations to operate on a cost-to-charge ratio of 1:1. Most clinics in CICP are FQHCs—in Fiscal Year 2001 all but 2 of the 17 participating clinics were FQHCs.

The Department determines providers' cost-to-charge ratios using data from federally required documents that each provider submits to the Department annually. By using

standard data for the cost-to-charge ratio, the Department intends to ensure that all providers' costs, and therefore their reimbursements, are calculated on an equitable basis. Specifically, each hospital must submit designated information on total facility costs and total facility charges from its Medicare hospital cost report, along with supporting documentation from the report. Each clinic is required to submit information on total facility costs and total facility charges from its Uniform Data System Report, along with supporting documentation. On the annual CICP provider application, the Department informs providers that a facility that wishes to submit anything other than these figures and documentation must submit a written explanation to the Department for approval.

In the course of our audit, we identified the following instances in which the Department either deviated from its stated method for calculating providers' cost-to-charge ratios without adequately documenting the rationale for these exceptions or did not acquire and maintain appropriate supporting documentation for the cost-to-charge ratio. This raises concerns about whether or not payments were calculated on an equitable basis.

- At the request of Denver Health and University Hospital, the Department used costs to calculate these facilities' cost-to-charge ratios that were different from, or in addition to, those required in the CICP provider application. In both cases, the Department did not obtain documentation from the providers that fully substantiated the basis for the information used in the ratios. HCPF staff indicate that since the providers asked for these changes, the changes probably had a favorable impact on the reimbursements for these providers. However, we found limited evidence that HCPF staff had analyzed the providers' requests. In other words, staff were not clear on the basis for the changes being requested; how the changes would impact the providers' cost-to-charge ratios, in comparison with the standard information requested in the application; and whether the changes were appropriate. In summary, there was no documentation in the files indicating the basis for the Department's decision to use the alternative information furnished by these providers as the basis for calculating these providers' cost-to-charge ratios.

  The Department states that in some cases it is appropriate to make adjustments to cost-to-charge ratios based on new information or because of unique circumstances. While we recognize that there may be instances in which deviations from the standard cost-to-charge methodology may be reasonable, the Department should clearly document the basis for its decision when exceptions are made.

- For hospitals that had observation beds costs, the Department included those costs in "total facility costs," although this is a deviation from HCPF's stated methodology in the provider application for calculating the cost-to-charge ratio.

For the 25 hospitals in our sample with observation beds costs, including these costs had a positive impact on reimbursement because it increased their respective cost-to-charge ratios. The Department's reason for including these costs was not documented, and the Department did not notify providers that a change in policy had occurred.

In Fiscal Year 2000, HCPF was still reconciling Outstate providers' estimated CICP costs to actual CICP costs, once all data for Fiscal Year 2000 had been submitted. We estimate that the Outstate hospitals in our sample received a total of about $67,000 more in Fiscal Year 2000 due to the inclusion of observation beds costs in their cost-to-charge ratios. This reduced the amount available to other Outstate providers.

As of Fiscal Year 2002, Outstate providers, like Component 1A providers, will be reimbursed on a prospective basis, which means that no year-end reconciliation will be performed between estimated and actual CICP costs. Because the Fiscal Year 2000 data are being used as the basis for Fiscal Year 2002 payment calculations, this deviation from policy related to observation beds costs is also incorporated into current year payments. We estimated that the Outstate and Component 1A hospitals' projected payments for Fiscal Year 2002 increased about $89,000 and $87,000, respectively, as a result of this past decision.

Further, in one instance the Department did not include observation beds costs for an Outstate hospital that, in fact, had these costs. If the Department's intent was to include these costs, then this provider was underpaid $2,200 in Fiscal Year 2000. This also translates into a projected underpayment of $2,900 for this provider in Fiscal Year 2002.

- For one Outstate provider, the Department used the cost-to-charge ratio reported by the provider, although the provider had not furnished any documentation to support the reported figures. In another case, the Department used the provider's reported cost-to-charge ratio, although the supporting documentation did not agree with the stated ratio. We did not find evidence that the Department had followed up with either provider to resolve these issues.

Additionally, we noted that the Department relies on data from Medicare cost reports that have not yet been audited as the basis for the cost-to-charge ratios. The Department already has a contractual relationship with one of the Medicare intermediaries for the Medicare program in the State. The Medicare intermediary is responsible for auditing providers' Medicare cost reports. By expanding that contract or entering into an additional one, HCPF could obtain audited data for the cost-to-charge ratios and thus

ensure greater reliability and consistency of these numbers as well as greater equity in calculating provider payments.

Formalization of the Reimbursement Process

Overall, the Department needs to formalize its reimbursement process in order to demonstrate that it is treating providers equitably. Many of these issues could be addressed by the Department's formalizing its policies with respect to the reimbursement process and following through when documentation is lacking or inadequate. In addition, the Department's policies related to reimbursement calculations should be clearly stated and communicated to providers. Finally, HCPF should base cost-to-charge ratios for providers on audited data.

Recommendation No. 12:

The Department of Health Care Policy and Financing should develop and implement controls over the reimbursement process for the Colorado Indigent Care Program by:

a. Applying the reimbursement methodology consistently to all providers within each CICP provider category and documenting the reasons for any exceptions from the standard methodology in the provider's file.

b. Obtaining audited information on which to base providers' cost-to-charge ratios.

c. Requiring in instances where audited information is not available that providers submit all necessary supporting documentation for calculating cost-to-charge ratios, reviewing this documentation for errors or problems and following up as appropriate, and maintaining all cost-to-charge ratio documentation in the provider's file.

d. Informing providers about all policies and procedures related to determining provider reimbursements.

Department of Health Care Policy and Finance Response:

Agree. The Department will examine the current controls over the reimbursement process and implement new procedures as necessary. The Department will maintain more documentation regarding this information and provide more information to affected providers. The Department will consider creating a separate contract with an outside entity to provide consistent audited information on which to base providers' cost-to-charge ratios. The Department will implement the procedures for making adjustments by October 31, 2002, so the information will be included with the final Fiscal Year 2001-2002 cost data submitted by CICP providers.

Component 1A Payment Calculation Method

During the audit the Department indicated that it uses different prospective payment calculation methods for the Component 1A hospitals and for the Outstate providers. There does not appear to be a rationale for the differences in the two methods, other than that they were developed at different points in time and have always been performed by different individuals.

We compared the two prospective payment methods, and we believe that the Component 1A method should be changed to be consistent with the Outstate method. Our primary concerns are those of equity and consistency. Although Component 1A hospitals and the Outstate providers are separate categories with different financing mechanisms and reimbursement levels, this does not create a need for determining CICP costs in a different manner. Further, the Component 1A payment method requires that the Department use additional estimates, which we found to be based on outdated and inaccurate information. As a result, Component 1A payments are not calculated on an equitable basis. Finally, the current Component 1A payment method is unnecessarily cumbersome when compared with the Outstate method, and this can create a greater risk of errors in calculations.

Differences Between Component 1A and Outstate Prospective Payment Methods

In both the Component 1A and Outstate categories, the goal of the prospective payment method is first to use CICP charges to estimate CICP costs and then to determine a

payment amount by applying a reimbursement percentage to those costs. The difference between the Component 1A and Outstate methods is how the Department arrives at estimated CICP costs for the year.

The methodology the Department uses to estimate write-off costs and calculate a prospective payment for the Outstate providers is as follows:

Method A: Outstate Providers

1. Total CICP Charges - (Third Party Payments + Patient Liability) = Write-Off Charges
2. Write-Off Charges × (Medicare Costs/Medicare Charges) = Write-Off Costs
3. Write-Off Costs × Two-Year Inflation Factor = Estimated Write-Off Costs
4. Estimated Write-Off Costs × Reimbursement Rate = Projected Payment for Year

Payments for the current year are based on actual write-off costs from two years ago that are inflated forward two years. Payments are then calculated using these estimated inflated write-off costs.

For Component 1A hospitals, the calculation to arrive at estimated costs differs primarily because of the treatment of patient liability and its conversion to estimated patient payments. The Component 1A method is outlined below.

Method B: Component 1A Providers

1. CICP Charges - Third Party Payments = Write-Off Charges including Patient Liability
2. Write-Off Charges including Patient Liability × Two-Year Inflation Factor = Inflated Write-Off Charges including Patient Liability
3. Inflated Write-Off Charges including Patient Liability × (Medicare Costs/Medicare Charges) = Est. Write-Off Costs including Patient Liability
4. Patient Liability × Two-Year Inflation Factor × Est. Patient Payment Percentage = Inflated Est. Patient Payments
5. Est. Write-Off Costs including Patient Liability (from Step 3) - Inflated Est. Patient Payments (from Step 4) = Est. Write-Off Costs
6. Est. Write-Off Costs × Reimbursement Rate = Projected Payment for Year

In the Component 1A method, total charges, less third party payments, are inflated forward two years and multiplied by the cost-to-charge ratio *before* any deduction is made for patient liability. Separately, the patient liability is inflated forward two years and multiplied by the facility's estimated payment percentage. The cost-to-charge ratio is not applied to the resulting estimated patient payments. Finally, the estimated patient payments are subtracted to arrive at estimated write-off costs.

We recalculated Fiscal Year 2002 payments for Component 1A providers using Method A for Outstate providers and the corrected figures for CICP charges and adjustments for University Hospital and Denver Health. (The discussion of these corrections can be found at Recommendation Nos. 6, 8, and 10.) We found that Component 1A providers' total reimbursements based on estimated CICP costs would be $1.6 million (2.4 percent) less under the Outstate method; however, the Department could easily compensate for this by slightly raising the reimbursement rate for this category. Additionally, we found that providers' respective "shares" of Component 1A monies changed by less than 1 percent of the provider's total Component 1A reimbursement under this scenario, ranging from -0.05 percent to +0.09 percent. Our estimates show that providers with the largest change in their share of reimbursement are those with the largest differential between their patient liability amounts and estimated patient payment amounts. We believe this shift among provider shares is appropriate because by using patient liability instead of estimated patient payments, the calculations are based on more accurate and current data. The problems with the patient payment estimates are discussed below.

Problems With Patient Payment Percentage Estimates

Under the current Component 1A payment method, the Department adjusts providers' total patient liability by a patient payment percentage (see Method B, Line 4) to arrive at estimated patient payments. The Department states that it makes this adjustment in order to reduce patient liability to the estimated amount *collected* from CICP patients by Component 1A hospitals.

We found that the patient payment percentages the Department uses are both outdated and inaccurate. The percentages range from 5 percent to 42.6 percent across the nine Component 1A providers for Fiscal Year 2002. For four providers, these percentages are based on a sample of CICP claims that the Department reviewed in 1991. In the 11 years since then, the Department has never updated these figures. The five remaining Fiscal Year 2002 Component 1A providers were not part of the original 1991 sample, and the Department uses payment percentages based on verbal information from the providers.

To determine the accuracy of the payment percentages, we reviewed current patient payment data for both Denver Health and University Hospital. We found that the actual

patient payment percentages were higher than those used by the Department from the 1991 sample, especially in the case of University Hospital. This is illustrated in Table 14.

Table 14: Colorado Indigent Care Program
Comparison of Patient Payment Percentages for Selected Providers

Provider	Patient Payment Percentage	
	Based on 1991 Sample[1]	Based on Provider Data
Denver Health	5.7%	12.3%[2]
University Hospital	8.4%	45.3%[3]

Source: Office of the State Auditor analysis of Department of Health Care Policy and Financing and provider data.

[1] In 1991 the Department calculated these percentages for CICP patient payments based on a sample of data from the respective providers.

[2] Denver Health CICP data for Fiscal Year 2001.

[3] University Hospital CICP data for Fiscal Year 2000.

Although we did not analyze patient payment data from the seven additional Component 1A providers, we spoke with five of these providers as part of our provider survey. In every case, the provider reported a percentage that was higher than the estimate used by the Department. Thus, the patient payment percentages used by HCPF do not provide an accurate or equitable basis for calculating reimbursements. When asked about plans to update these percentages, the Department reported that it lacked the administrative resources necessary to conduct another sample.

Advantages of Outstate Method

The Department should maintain as much consistency as possible between the Component 1A and Outstate calculation methods for the program. By aligning these two payment methods, the Department can streamline the Component 1A calculations and help ensure that calculations of CICP write-off costs for all providers are performed using a common basis, regardless of whether the providers are in the Component 1A or Outstate categories. Since the Department lacks administrative resources to update patient payment information, this further supports the argument to make the Component 1A method consistent with the Outstate method. If inaccurate estimates are used to calculate Component 1A payments, providers are not being treated equitably.

Also, adopting the Outstate payment method for the Component 1A providers is advantageous because it would make it easier for Department staff to be cross- trained in

the payment methods and to review each other's work. This would contribute to the accuracy and consistency of the payment process. Finally, as mentioned in Chapter 1, Component 1A providers receive bad debt payments in partial payment for unpaid portions of patient liability. Thus, Component 1A providers already receive some CICP monies toward unpaid patient liability through that financing mechanism.

Recommendation No. 13:

The Department of Health Care Policy and Financing should consider revising the Component 1A prospective payment calculation method to be consistent with that used for the Outstate providers.

Department of Health Care Policy and Financing Response:

Agree. The Department will examine aligning the two payment theories in the report due to the General Assembly on December 1, 2002. The Department feels that the current payment methodology is correctly calculated, but will seek to simplify both the methodology utilized and the administrative workload. If the Department continues to use the current payment methodology, the patient payment percentages will be updated. Any formal change in the distribution of payment methodology of Component 1A appropriated funds would require approval from the Governor's Office of State Planning and Budgeting for the Department, prior to submittal to the General Assembly for final consideration.

Administration

Chapter 3

Introduction

As noted earlier, for Fiscal Year 2002 the Colorado Indigent Care Program (CICP) has 68 participating providers in 45 of the State's 64 counties. Approximately $86.7 million in reimbursements based on CICP charges will be paid to these providers in Fiscal Year 2002. The Department of Health Care Policy and Financing (HCPF) administers CICP. Among other things, HCPF is responsible for communicating program requirements and policies to providers, collecting data on charges related to CICP services, and monitoring the program's audit requirement. Under CICP, providers are to submit audits of CICP annually.

In addition to submitting data on CICP charges and annual audits, CICP providers are responsible for determining individuals' eligibility for CICP services. Providers are also responsible for prioritizing services to CICP patients in accordance with statutes, which require that providers manage CICP monies to ensure emergency care is available for the entire year. Beyond emergency services, statutes specify that providers are required only to give services to the extent of their physical, financial, and staff resources.

In addition to our review of the Department's process for determining provider payments, described in Chapter 2, we examined other administrative aspects of CICP. These include the Department's process for certification of public expenditures by participating public hospitals, the adequacy of HCPF's audit function for CICP, and communications with providers on program requirements.

We found that the Department needs to improve its process for certification of public expenditures by public hospitals to ensure federal draws are based on appropriate expenditures. Additionally, in view of the problems identified in Chapter 2, the Department should reassess the audit function for CICP in order to increase its effectiveness and more appropriately target audits toward providers that represent the greatest risk for the program. Further, the Department should continue to improve communications with providers.

Ensuring Certified Expenditures Are Appropriate

Our audit examined the Department's process for overseeing the certification of public expenditures by public hospitals in CICP. During Fiscal Year 1998 the State began to use certified expenditures made by some of these facilities as the basis for drawing down federal funds in place of spending state general funds. In Fiscal Year 2001, Denver Health Medical Center (Denver Health) and the University of Colorado Hospital (University Hospital) together certified about $165.9 million in expenditures to the State ($42.3 million related to payments under the Major Teaching Hospital program and $123.6 million related to Component 1A payments for CICP services under the Disproportionate Share Hospital program). In turn, on the basis of these certified amounts, the Department drew about $83 million in federal funds, which the State then paid to these two providers.

Certification has significantly decreased the use of general funds for CICP, thereby freeing up funds for other purposes. The Department is awaiting approval from the federal Centers for Medicare and Medicaid Services (CMS) for a new amendment to the State Plan that would extend the use of certification to 18 public hospitals in the Outstate hospital category. If approved, this will further decrease the use of state general funds for CICP.

While the use of certified expenditures has obvious advantages for the State, it also presents some risks because the State is relying on information from other entities as the basis for drawing federal funds. Because the State is the entity actually drawing these funds—and the entity statutorily responsible for oversight of the Medicaid program for the State—the Department needs to ensure expenditures certified by other entities are appropriate. We reviewed the Department's procedures for certification and concluded that HCPF should implement reconciliations to ensure that certified expenditures, which are based on cost estimates, are supported by actual costs. Additionally, the Department should take steps to ensure that providers do not receive other federal reimbursement for certified expenditures.

Comparison of Certified Expenditures to Actual Costs Incurred

The Department notifies Denver Health and University Hospital at the beginning of the fiscal year of the amount of public expenditures each hospital will need to certify quarterly in order for the State to draw the necessary federal funds to make the projected payments for the year to these facilities. The Department also furnishes the wording that providers are to use in the letters sent to HCPF to document their

quarterly certification of expenditures. The Department maintains a worksheet to track receipt of the letters and the amounts certified. Staff indicate that the purpose of the certification letters is to have the supporting documentation from the providers for the expenditures, since these expenditures are the basis for the federal draws.

The Department determines the amount of expenditures to be certified by Denver Health and by University Hospital annually on the basis of the projected payments each facility is to receive for the fiscal year. As described in Chapter 2, payments are partial reimbursement for the CICP costs incurred by the provider for services furnished to CICP-eligible individuals. The Department estimates these costs using CICP charges submitted two years prior; for example, Fiscal Year 2002 payments are based on Fiscal Year 2000 CICP charges and estimated costs. Because the Department calculates Fiscal Year 2002 payments using estimated costs, the certification amounts themselves for Fiscal Year 2002 are based on these same estimated costs.

To ensure that certified expenditures were not excessive, we compared the amounts certified by Denver Health and University Hospital for Fiscal Years 2000 and 2001 with actual CICP write-off costs for those years. For Denver Health, we did not identify instances in which certified Component 1A costs were greater than actual write-off costs for either year. In the case of University Hospital, we did not identify problems with amounts certified for Component 1A payments for Fiscal Year 2000. However, in Fiscal Year 2001, University Hospital certified Component 1A costs that *exceeded* actual write-off costs by $1.8 million. In other words, the certified amounts the Department used to draw down federal funds for University Hospital's Component 1A payments were greater than University Hospital's actual CICP costs in Fiscal Year 2001. Under the Medicaid program, the federal government will reimburse half, or 50 percent, of qualifying expenditures or costs. This means that the Department's draw of about $900,000 (50 percent of the $1.8 million) in federal funds was based on estimated costs not supported by actual expenditures made by University Hospital.

HCPF staff state that the federal government has approved the Department's methodology for using estimated costs as the basis for calculating payments to Component 1A providers and is aware that the Department uses certification as the basis for drawing the federal funds used for paying Denver Health and University Hospital. Therefore, staff indicate that HCPF need not perform a reconciliation between estimated and actual costs and that, in fact, such a reconciliation is exactly what the prospective payment method was created to avoid. The prospective payment method was adopted because of the problems that performing year-end reconciliations caused with budgeting and the impact on other providers' payments, since all providers are paid from one pool of funds. Accordingly, HCPF staff do not believe it is necessary to ensure that certified expenditures do not exceed actual costs for a specific fiscal year. Additionally, staff point out that public providers have

additional qualifying expenditures under the bad debt amendment to the State Plan, and any shortfall in certifiable expenditures under the Component 1A amendment could easily be made up by certifying additional bad debt costs.

Under federal regulations, federal reimbursements must be based on actual expenditures. Therefore, we believe that amounts certified as public expenditures based on estimates under Component 1A must be reconciled to actual costs as defined in the State Plan under that amendment to ensure that certified amounts are at least equal to actual expenditures. With respect to substituting bad debt costs for any shortfall in certifiable CICP costs under the Component 1A amendment, this would require that the Department mix the sources of certified expenditures between two different State Plan amendments. The Department should confirm with the federal Centers for Medicare and Medicaid Services that this is an acceptable remedy. In any case, without formally reconciling certified amounts based on estimated costs and actual costs for Component 1A, the Department could not be assured that it would identify shortfalls in actual costs.

Receipt of Other Federal Funds

The Department should also ensure that public hospitals are aware that certified expenditures are used by the State as the basis for drawing federal funds, especially as HCPF asks more hospitals to certify their CICP costs as public expenditures. In particular, providers need to be aware that federal regulations prohibit the same expenditure from being reimbursed under two different federal programs. In other words, the hospitals cannot certify expenditures to the State for CICP that are reimbursed by other federal funds, either in whole or in part.

We found that the language provided by the Department and used by the hospitals to certify expenditures does not require that the hospital provide assurance that it did not receive any other federal funds as reimbursement for these expenditures. The Department should incorporate such language into the format given to providers for quarterly certification letters to avoid any misunderstanding and possible improper certification of expenditures.

Certification has proven to be an increasingly important financing tool for the State because of the relief it offers in the use of state general funds. The Department should ensure that the risks associated with certification are addressed and that these expenditures are an appropriate basis for drawing federal funds.

Recommendation No. 14:

The Department of Health Care Policy and Financing should improve controls over the certification process for the Colorado Indigent Care Program by:

a. Formally documenting annual comparisons of certified public expenditures by each provider to the provider's actual CICP write-off costs for each applicable fiscal year for Component 1A. Similar reconciliations should be done for any future State Plan amendments in which certification is based on estimated costs.

b. Obtaining confirmation from the federal Centers for Medicare and Medicaid Services on whether shortfalls in certified expenditures under Component 1A may be offset by excess certifiable expenditures under a different amendment to the State Plan. If this is not acceptable, the Department should make the necessary adjustments in federal draws to offset excess amounts received.

c. Informing providers of the purpose of certification and that expenditures cannot be certified if they are reimbursed by other federal funds.

d. Requiring that providers include an assurance in each quarterly certification letter stating that no federal funds were received as reimbursement for the certified expenditures, other than those through CICP.

Department of Health Care Policy and Financing Response:

Partially agree. The Department does not plan to formally document annual comparisons of certified public expenditures to each provider's actual write-off costs. The federally approved prospective payment system used by the Department is designed to be an estimate and is not intended to be reconciled to actual. Increases or decreases in actual costs will impact CICP payments two years in the future. The Department will contact CMS regarding shortfalls from one State Plan amendment to another. The Department will inform providers that expenditures cannot be certified if they are reimbursed by other federal funds and require that providers include an assurance in the certification letters that no federal funds other than those from CICP were received as reimbursement for the certified expenditures. The Department will implement policy clarifications by July 1, 2002.

Assessing Options for the Audit Function

Audits are an important internal control mechanism in any organization because they provide an independent assessment of how well organizations are meeting their goals, objectives, and related requirements. Therefore, the audit function must be designed to effectively identify obstacles and problems in order that these can be addressed. At the same time, the audit function should not create a burden that exceeds the benefits obtained.

In the case of the Colorado Indigent Care Program, the audit function is not as effective at identifying problems as it should be. At the same time, it is overly burdensome for providers who receive relatively small payments. To address these two concerns, the Department itself must assume at least part of the responsibility for performing on-site audits of CICP providers. Additionally, HCPF should reassess the provider audit requirement with respect to the amount of CICP funds paid to providers and the providers' cost of completing the audits.

Role of HCPF

The Department of Health Care Policy and Financing has completely delegated the audit function to providers in the form of the provider audit requirements. While these requirements have merit, the problems we identified in Chapter 2 indicate that the Department needs to perform periodic on-site detailed testing of CICP charges, especially at the program's large providers or where there are other indications of risk, such as high reported error rates in provider audits that persist over a period of time. The Department is more familiar with CICP than external auditors, and it is in a better position to assess problems from the State's perspective.

Impact of HIPAA on Data Collection for CICP

Another reason that the Department must take a greater role in auditing charges on-site is that the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) will impact HCPF's ability to collect detailed information on CICP charges from all providers. This law is designed to protect individuals' confidential health care information through improved security standards and federal privacy legislation. The final federal privacy rule for HIPAA was published in December 2000, and covered entities that administer health care services, such as HCPF, have until April 14, 2003, to comply. The Department states that the impact of HIPAA on its ability to collect data on health care services will be far-reaching and that complying with requirements will be costly for the State.

The Department has contracted with a private consultant to evaluate options for bringing HCPF's health care programs, such as Medicaid, the Children's Basic Health Plan, and CICP into compliance with HIPAA. If a program's data, such as Medicaid claims, can be made compliant with HIPAA privacy and transaction requirements, then HCPF can continue to receive detailed information on individual charges under the program.

At the conclusion of our audit, the Department had not yet received the contractor's final report, and therefore it is not certain what options will be available to the State or the costs involved. However, HCPF staff indicate that HIPAA compliance will be achieved for the Medicaid program, which has expenditures of approximately $2 billion annually. Concerning CICP, HCPF staff believe that it will be cost-prohibitive to make CICP detailed data compliant with HIPAA, and thus it is unlikely that the Department will be able to require detailed data from any CICP provider once HIPAA is in place.

Without making CICP detailed data compliant with HIPAA, HCPF will soon be entirely dependent upon summary information submitted by all providers as the sole basis for calculating CICP payments. As reported earlier, payments made on the basis of CICP charges amounted to $89.3 million in Fiscal Year 2001. Our review of HIPAA guidelines indicates that the Department, as a business partner of the providers, will likely be able to access CICP charge data at the providers' facilities. Assuming that this is the case, and given the inherent limitations of relying completely on external audits by the providers' auditors, we believe the Department must perform some measure of on-site testing.

Provider Audit Requirement

With respect to provider audits, the Department should reevaluate the criteria used to determine which providers must submit external audits. CICP guidelines require any provider with total write-off charges of more than $25,000 for the fiscal year to have an external independent audit. Providers below this threshold are required to submit internal audits. We determined that the current requirement results in external audits covering 99.98 percent of total write-off charges and almost 94 percent of all providers. This level of coverage by external audits is probably higher than the program requires. Raising the $25,000 threshold could focus the audits toward providers that present the highest risk. Also, these larger providers are more likely to be able to absorb the cost of the audits. According to our provider survey, audit costs average from $2,500 to $3,000. The Department could continue to require internal audits for providers below the threshold; these are reported to be considerably less expensive.

We analyzed the impact on audit coverage from raising the threshold for the annual audit requirement. We used write-off charges as the basis for our analysis; however, other measures could be used, such as reimbursement paid to providers. Our results are summarized below in Table 15.

Table 15: Colorado Indigent Care Program
Impact of Audit Threshold on Audit Coverage
Based on Fiscal Year 2001 Provider Write-Off Charges

Threshold for External Audit, Based on Write-Off Charges and Provider Category	CICP Write-Off Charges Subject to External Audit (Total Write-Off Charges: $341,360,361)		Providers Required to Submit External Audits (Total Providers: 66)	
	Amount	% of Total Write-Off Charges	Number	% of Total Providers
Option A: > $25,000; All Categories[1]	$341,300,632	99.98%	62	93.94%
Option B: > $500,000; All Categories	$336,794,632	98.66%	41	62.12%
Option C: > $500,000; Outstate only *All Component 1A Subject to External Audit*	$337,488,132	98.87%	43	65.15%
Option D: Component 1A/Major Teaching Hospitals Only (Denver Health and University Hospital)	$188,188,889	55.13%	2	3.03%

Source: Office of the State Auditor analysis of Department of Health Care Policy and Financing data.
[1] This is the threshold for determining which providers must have annual external audits under current CICP guidelines. Providers under this threshold must conduct internal audits, which also must be submitted to the Department.

Option A shows the results of the present audit requirement. Option B shows that by raising the threshold to $500,000 for all providers, the percent of coverage falls only slightly, while the percentage of providers required to have the audits drops to about 62 percent, or to 41 providers. Under Option C, the coverage is slightly higher because, unlike Option B, in this option all Component 1A hospitals would be required to have external audits due to the substantially higher reimbursement rates they receive.

Option D is included only to demonstrate that Denver Health and University Hospital alone account for over 55 percent of write-off charges, even though they represent

only 3 percent of the providers. Thus, these two providers present significantly higher risk based on write-off charges. This further implies the need for closer scrutiny of these providers' charges.

Factors to Consider in Designing the Audit Function

The Department has a number of options to consider when redesigning the audit function to increase its effectiveness and lessen the burden on smaller providers. In terms of the Department's role, it could limit its on-site reviews to Denver Health and University Hospital and other instances in which particular risk is identified, or it could perform all independent audits itself. The audits could be conducted periodically on the basis of risk and other factors, and providers could be required to maintain supporting documentation and conduct annual internal audits. The Department could contract with a public accounting firm to perform this function, similar to other audit functions for which the Department contracts. Assuming that the external audits cost each provider at least $2,500, for Fiscal Year 2001, these providers paid about $155,000 in total for CICP audits. The State could probably contract for less than that to have audits performed on a selection of providers during the year. However, although the overall cost for the audits would be less, this approach would require that the State assume the cost of the audits, which is currently covered by the providers. Alternatively, the State could recover the cost of the audits by deducting a fee from providers' reimbursements.

Once the Department has determined its role in the audit function, it should assess the level of coverage by external audits that the program requires and implement the necessary audit requirements. These efforts will enable HCPF both to strengthen the audit function and better identify problems with charges and to decrease the burden on smaller providers in CICP.

Recommendation No. 15:

The Department of Health Care Policy and Financing should increase the effectiveness of the audit function for the Colorado Indigent Care Program by:

a. Assessing its role in on-site audits for the program and performing audits on the program's providers that represent the highest risk on a periodic basis.

b. Considering the option of contracting with a public accounting firm to perform on-site audits of the program.

c. Revising the provider audit requirement to more appropriately reflect the level of risk represented by providers, as well as the cost of the audits to providers who receive relatively low payments under the program.

Department of Health Care Policy and Financing Response:

Agree. The Department requested that the Office of the State Auditor examine this element of CICP in detail during this performance audit and appreciates all input on this topic. The Department will make changes to the Fiscal Year 2002-2003 CICP Manual to be issued by July 1, 2002, to more appropriately reflect the level of risk represented by providers as well as the cost of audits to providers who receive relatively low payments under the program. Currently the Department does not have the funding or the FTE available to perform on-site audits or to contract with a public accounting firm to perform any additional auditing functions. The Department will consider submitting a request for additional resources to perform this function through the Governor's Office of State Planning and Budgeting, subject to submittal to and approval by the General Assembly. The earliest the Department would expect legislative action would be the 2003 session of the General Assembly.

Auditor's Addendum

If the decision ultimately is made to continue to reimburse CICP providers primarily on the basis of CICP costs derived from CICP charges (see Recommendation No. 1), the Department must implement controls to ensure the accuracy and appropriateness of those charges, including on-site audits performed on the basis of risk. Without these controls, requesting data on CICP services from providers is not a meaningful requirement.

Ensuring Provider Audits Are Reviewed

While the Department needs to reevaluate the audit function for CICP, it also needs to ensure that the provider audits submitted are adequately reviewed and followed up on if it retains the provider audit requirement. Eligibility determination is a critical function in any program in which services are intended only for a specific group. Without effective controls over this process, services may not be focused toward the target population, which means that funds may not be spent in accordance with the program's purpose. Under CICP, eligibility is determined by each participating provider. Thus, eligibility is determined by a wide variety of entities across the State.

The provider audits are designed to identify and report problems that providers have with determining eligibility for CICP.

We reviewed the Department's files to determine if audits were routinely submitted by the providers and if CICP staff were reviewing the audits and following up on identified problems. We found that the Department does not receive all required audits or corrective action plans and does not follow up with providers.

Submission of Audits

The CICP audits are due to HCPF within 90 days after completion of the provider's annual financial audit. Program guidelines require providers to submit a corrective action plan along with the audit if one or more error rates exceed 10 percent for a specific area of testing or for an attribute. Auditors are required to test a sample of CICP applications for attributes such as whether the application is signed, income is appropriately documented, and the patient's financial rating is correctly calculated. If the provider does not submit a corrective action plan when error rates are too high, program staff are to notify the provider that a corrective action plan should be forwarded to HCPF. The purpose of the corrective action plan is for the provider to describe how the problems reported in the audit will be addressed.

We found that although the Department has a mechanism for tracking the audits, it had not been kept current to reflect all audits submitted. We also found that the Department did not have all required audits on file for Fiscal Years 1997, 1998, or 1999. For 1999 there were 14 audits due to HCPF but not on file; this represents almost 21 percent of all provider audits required for that year. These 14 providers were paid almost $2.6 million during that year. Table 16 summarizes our results.

Table 16: Colorado Indigent Care Program
Audit Submission Rates
Fiscal Years 1997 Through Fiscal Year 1999

Fiscal Year	No. of Audits Due	No. of Audits on File	No. of Audits Not on File	% of Audits Not on File
1999	67	53	14	20.9%
1998	64	53	11	17.2%
1997	61	53	8	13.1%

Source: Office of the State Auditor analysis of Department of Health Care Policy and Financing data.

Additionally, we found two providers that had no audits on file with the Department for any of the three years, and five that had no audits on file for the two most recent years. Staff report that the Department does not withhold payments from a provider because of the provider's failure to submit audits. Thus, the Department is not consistent with program guidelines that state that funds will be withheld if audits are not submitted.

During our survey of 25 providers, discussed later in this chapter, we learned that one of the providers that had not submitted any audits for these three years was unaware that the program had an annual audit requirement. In another instance, a provider was unaware that CICP had an asset test as part of eligibility determination. This second provider had not submitted audits during its two years of participation in CICP, stating it was unsure how the audits were to be completed. Both of these providers should have had external CICP audits completed annually under program guidelines. These instances could have been addressed, had the Department been monitoring provider audits. In general, surveyed providers responded that the Department did not consistently communicate whether or not the audits had been received or had met requirements.

Review of Audits

We conducted detailed testing on a sample of 25 providers and their audits for this same three-year period. We found that the Department had reviewed the majority of the audits on file for these providers. However, in some instances there was no evidence of review. For example, we could not identify evidence of review for two audits for Fiscal Year 1999.

Additionally, the Department does not routinely follow up with providers in cases where a corrective action plan should have been submitted along with the audit, because error rates exceeded 10 percent. Out of the 16 Fiscal Year 1999 audits staff had reviewed, 7 of these should have been submitted with a corrective action plan. When reviewing the types of errors that led to the excessive error rates in these cases, we found the following (some had excessive rates in more than one category): four of the seven providers had high error rates due to the lack of documentation, such as an application indicating the person was eligible for CICP; four did not have documentation supporting the individual's income and allowable deductions for expenses; and three had high errors related to patient copayments. These are all significant errors that can impact the amount of CICP charges submitted to the Department.

Of the seven providers that should have submitted corrective action plans for Fiscal Year 1999, only one provider had submitted this plan and there was no indication that HCPF had contacted the other six providers and requested the required plans.

Further, in two cases staff had erroneously noted in the provider's file that the audit was in "full compliance." In other words, staff's review did not note that a corrective action plan should have been filed because of high error rates. Our results are summarized in Table 17.

Table 17: Colorado Indigent Care Program
Department Review of Provider Audits
Fiscal Years 1997 Through 1999
(Sample Size: 25 Providers)

	Audits on file			Audits With Error Rates > 10%		
		Audits Reviewed			Corrective Action Plans Received	
Fiscal Year	No. of Audits on File	No.	As % of Audits on File	No.	No.	As % of Audits With Error Rates > 10%
1999	18	16	88.9%	7	1	14.3%
1998	20	19	95.0%	5	2	40.0%
1997	22	20	90.9%	6	3	50.0%

Source: Office of the State Auditor analysis of Department of Health Care Policy and Financing data.

We also noted that the number of providers required to submit corrective action plans had remained about the same over the three-year period, while the number of corrective action plans submitted to HCPF decreased from three to one. This suggests that the Department is doing less to enforce the corrective action plan requirement.

In order to ensure payments are based on allowable services to eligible individuals and that charges are accurate, the Department should establish adequate monitoring and follow-up procedures for provider audits. In addition, the Department should enforce penalties as appropriate if providers do not adhere to program audit requirements.

Recommendation No. 16:

The Department of Health Care Policy and Financing should improve procedures for monitoring provider audits for the Colorado Indigent Care Program by:

a. Maintaining current data on the receipt and review of, and response to, all required provider audits.

b. Following up with providers in instances where audits have not been submitted within required time frames.

c. Requiring corrective action plans in all instances required under program guidelines.

d. Assessing the need to withhold payments or eliminate providers from the program in cases where the provider does not comply with audit requirements.

Department of Health Care Policy and Financing Response:

Agree. The Department will endeavor to follow the procedures for the CICP provider audits already in place. Due to limited staffing, these procedures have taken a secondary role. The Department will implement new procedures by July 1, 2002.

Audit Testing Requirements

The CICP manual states that the "purpose of the audit requirement is to furnish the Department of Health Care Policy and Financing with a separate audit report that attests to provider compliance with specified provisions of the CICP's contract and related manuals." The manual gives guidelines for the auditors that are intended to provide the basis for conducting the audit.

We reviewed the areas auditors are required to test for CICP to determine if these give reasonable assurance that payments to providers are based on accurate and complete information. CICP guidelines require that auditors test various attributes, or characteristics, for a sample of CICP applications. In addition, guidelines require that the auditors report on six additional compliance areas such as adherence to legislative medical service priorities, availability of a patient appeals process, and verification of executed contracts with CICP subcontractors. We found that the Department needs to revise the requirements in order to ensure that (1) requirements are adequately balanced between testing eligibility and CICP charges and (2) requirements are internally consistent and measure meaningful results. In addition, HCPF should develop a form for auditors to use when reporting results.

Balance between testing eligibility and charges. Auditors are required to select a sample of applications and test for compliance with nine attributes, such as whether the original application is on file, the application was signed, income and other

financial information is documented, and the correct rating was calculated. The rating is assigned on the basis of the person's net income and assets and determines the amount of copayments the person must pay.

Despite the fact that payments to providers are based on CICP charges, only two of these nine attributes are related to charges, and there are no attributes that test the actual charge itself. One of these two attributes requires the auditors to verify that the correct copayment was charged. The other requires that if the person has other insurance ("third party coverage"), the auditor must verify that the provider sought payment from the insurance company and that third party payments are applied against total write-off charges when billed to HCPF.

More testing should be performed on charges to address the risk of erroneous charges being submitted to HCPF. Specifically:

- The sample for testing the nine attributes should be selected from the total CICP charges submitted for the most recent year for which the CICP annual report has been issued, instead of from applications. Eligibility should be tested for the individuals who received the services upon which the charges in the sample are based.

- For the sample charges, the auditors should ensure that CICP patients were billed the same amount for the same services as other patients at that time.

- The auditors should be required to verify that the provider has maintained documentation, such as a detailed listing of specific charges that can be traced to its billing system, to support all charges and adjustments submitted to HCPF, including those submitted on behalf of subcontractors.

Internal consistency of attributes for eligibility. Seven attributes address various aspects of eligibility, ranging from correctly completing a signed application to determining that clients are not eligible for Medicaid. However, some attributes are inconsistent. In particular, the first attribute requires that the auditor verify that an original application or alternative documentation for the patient is on file. CICP guidelines allow for alternative documents, such as a screening document from another provider, in cases where eligibility was determined by a different provider. Under CICP, providers are required to accept each other's ratings.

On the other hand, other attributes require a review of the application itself (e.g., verification that the application was signed). According to some providers, the external auditors require that applications be obtained from the other provider in instances where a client is rated at another facility. If the applications are obtained and the auditors identify errors in these applications, the errors are charged to the provider being audited.

As a result, contrary to the intent of the audits, eligibility error rates may not accurately reflect the performance of the provider being audited. CICP guidelines should instruct the auditors to indicate as "not applicable" those attributes that cannot be tested without the original application in cases where another provider determined eligibility and acceptable alternative documentation was provided by the patient.

Reporting audit results. CICP guidelines require that auditors report results on all required areas of testing. However, we noted that some auditors failed to report on all areas. Of the audits submitted between Fiscal Years 1997 and 1999 for our sample of providers, in eight reports auditors did not submit error rates for all attributes. Further, we found that 45 percent of the audit reports did not report on the six additional compliance areas such as legislative medical services priorities. If auditors do not report on requirements, the Department has no way of determining whether all items were tested or if problems were found. The Department should furnish a form in the CICP manual with the audit guidelines that auditors are to use to report results. The form should delineate all areas that need to be reported.

By revising the testing requirements for CICP audits, the Department can obtain greater assurance that charges submitted are appropriate and that error rates more accurately reflect the performance of the provider submitting the audit. By developing a standard form for auditors to use for reporting audit results, the Department would help ensure that all requirements are tested and the results are reported for its review.

Recommendation No. 17:

The Department of Health Care Policy and Financing should revise the testing requirements for Colorado Indigent Care Program provider audits to ensure audits accurately reflect and report on areas of greatest risk by:

a. Requiring that auditors base their testing on a sample of charges and verify that CICP recipients were charged amounts consistent with other patients. Auditors should also confirm that the provider's detailed information on charges supports amounts reported to the Department for total charges, third party payments including contractual adjustments, and patient liability.

b. Revising eligibility testing requirements in order that error rates reflect eligibility determination for the provider that is being audited.

c. Developing a standard form for auditors to use for reporting audit results that lists all required areas of testing.

Department of Health Care Policy and Financing Response:

Agree. The Department requested that the State Auditor's Office examine this element of the CICP in detail during this performance audit and appreciates all input on this topic. The Department plans to have these guidelines in the Fiscal Year 2002-2003 CICP Manual. Implementation Date: July 1, 2002.

Communication and Provider Feedback

Our audit also reviewed how the Department communicates with providers. The Department has several ways in which it furnishes information about program requirements and receives feedback. These include:

- CICP Provider Advisory Panel, which is made up of representatives from the various categories of providers that participate in the program. This group meets quarterly with Department staff to discuss program policy, concerns providers might have, and changes that the Department anticipates for the program.

- CICP provider manual, which includes program definitions, statutes, application materials, eligibility requirements, and audit requirements. It also contains a billing section, which describes how charges should be submitted to HCPF each year. Department staff update this manual annually and distribute it to providers.

- Provider newsletter, which seeks to keep providers informed about anticipated changes, policy clarifications, or other matters of interest. HCPF issued the first and second newsletters in August and November 2001 and intends to send these to providers quarterly.

- Eligibility training workshops, which are designed to help providers determine CICP eligibility accurately. With the hiring of an Eligibility Specialist last year, the Department began to conduct workshops on eligibility throughout the Denver and Colorado Springs metropolitan areas. The Department reports that additional sessions will be scheduled on the Western Slope and San Luis Valley areas starting in the spring of 2002.

HCPF staff are also frequently contacted by providers over questions about eligibility, submission of data, payments, or other matters.

In addition to conducting interviews and performing site visits at Denver Health and University Hospital, we conducted a survey of 25 other CICP providers. As mentioned earlier, Denver Health and University Hospital receive the majority of CICP provider payments. Our purpose was to obtain feedback about the program from providers who receive less funding from CICP and may be less able to bear the administrative costs of the program. Our survey included 5 Component 1A hospitals, 13 Outstate hospitals, and 7 Outstate clinics. Providers chosen are located in a range of geographical areas and receive varying amounts of payments under CICP.

Beyond some general background questions, our inquiries addressed the CICP audit requirements, the eligibility determination process, data submission requirements, and communications. Our survey did not focus on the different reimbursement rates among providers.

In terms of the administrative burden of CICP, we found providers had a range of opinions regarding the impact of program requirements:

- **Eligibility determination**. Eighteen (72 percent) of the twenty-five providers reported that, in general, the eligibility process is not overly burdensome. The amount of time required is largely dependent upon the applicant's ability to furnish the necessary documentation. The most time-consuming applications are those for the self-employed. This is an area where some would like further guidance or clarification from HCPF.

  Providers were about evenly split on whether eliminating the asset test for CICP would be a positive move for the program. Some providers believed it would simplify eligibility determination, and others said that most applicants do not have assets in any case. However, some expressed concerns about widening the pool of possible applicants when funds for the program are limited.

- **Annual audit requirement**. Of the 23 providers who responded to questions about the audits, 13 (57 percent) said the audits were not excessively burdensome. However, 10 providers said the audits were excessive because of their cost, the demands on staff, or both. Generally, the cost of the audits ranges between $2,500 and $3,000 annually. Some providers indicated that the low reimbursement rates under CICP, combined with the cost of requirements such as the audits, can be a deterrent to participation in the program. All but 1 of these 10 providers are in the Outstate program and thus receive at most 30 percent reimbursement of their CICP write-off costs.

All providers reported that they review the audits upon completion, and 19 said they receive useful feedback from the audits with respect to their operations.

- **Data submission requirements**. Fourteen (56 percent) of the twenty-five providers reported some degree of difficulty or burden as a result of the most recent change in data submission requirements, mainly due to the need to reprogram systems or similar issues. The Department has changed the data submission procedures three times in the last three fiscal years, and providers stressed the need for consistency in these requirements.

  Providers expressed frustration over the Department's unsuccessful attempt to have the State's Medicaid fiscal agent, Consultec, Inc., (now known as Affiliated Computer Systems, Inc.) process CICP charges. This effort started at the beginning of Fiscal Year 1999. The Department officially terminated its CICP contract with Consultec on January 31, 2001, because of excessive costs and because providers reported pervasive and ongoing problems with reconciling the charges submitted to Consultec to the reports they received. Since abandoning this attempt, the Department has worked with providers to develop a simpler, in-house system for tracking charges. The change to an in-house system also contributed to the Department's decision to require only summary data for Fiscal Year 2002 from all providers except the three with the highest utilization (discussed in Chapter 2, Recommendation No. 9). Currently the data requirements appear to have stabilized, which should relieve some of the burden on providers and increase the accuracy and timeliness of data submission.

Continue Communication Efforts

In terms of communications, most providers in our survey gave the Department positive marks for responding to specific inquiries about the program and report receiving adequate technical support. However, we found some indication that the Department needs to ensure that its broader efforts to communicate information about CICP and its requirements are effective. For example, several providers had questions about the basis for their reimbursements or about possible changes in how reimbursements will be calculated. Additionally, one provider who has participated for several years was unaware that the program has an annual audit requirement, and another was not aware that the program has an asset test (these two issues are addressed earlier in this chapter in the discussion about provider audits).

Further, when asked how the program could be improved, the most common response was that providers wanted more communication on different aspects of the program, as well as proposed changes to program rules, requirements, and

reimbursement methods. In addition, providers emphasized the need for the Department to be consistent as much as possible from year to year with program requirements, in particular with respect to data submission requirements.

The Department has taken positive steps toward improving communications and relations with providers over the last several years, such as initiating the eligibility workshops and the quarterly newsletter. It should continue to establish ways for distributing program information through such means as expanding the information available on the Department's Web site and following through with plans to conduct eligibility workshops in other areas of the State beyond the Denver and Colorado Springs metropolitan areas. This will promote more consistency in the program statewide and will enable the Department to obtain feedback on ways to improve CICP and keep administrative requirements as reasonable as possible. This is particularly important for providers in the Outstate program that receive relatively low reimbursement but furnish access to CICP services in areas of the State with limited availability of health care services.

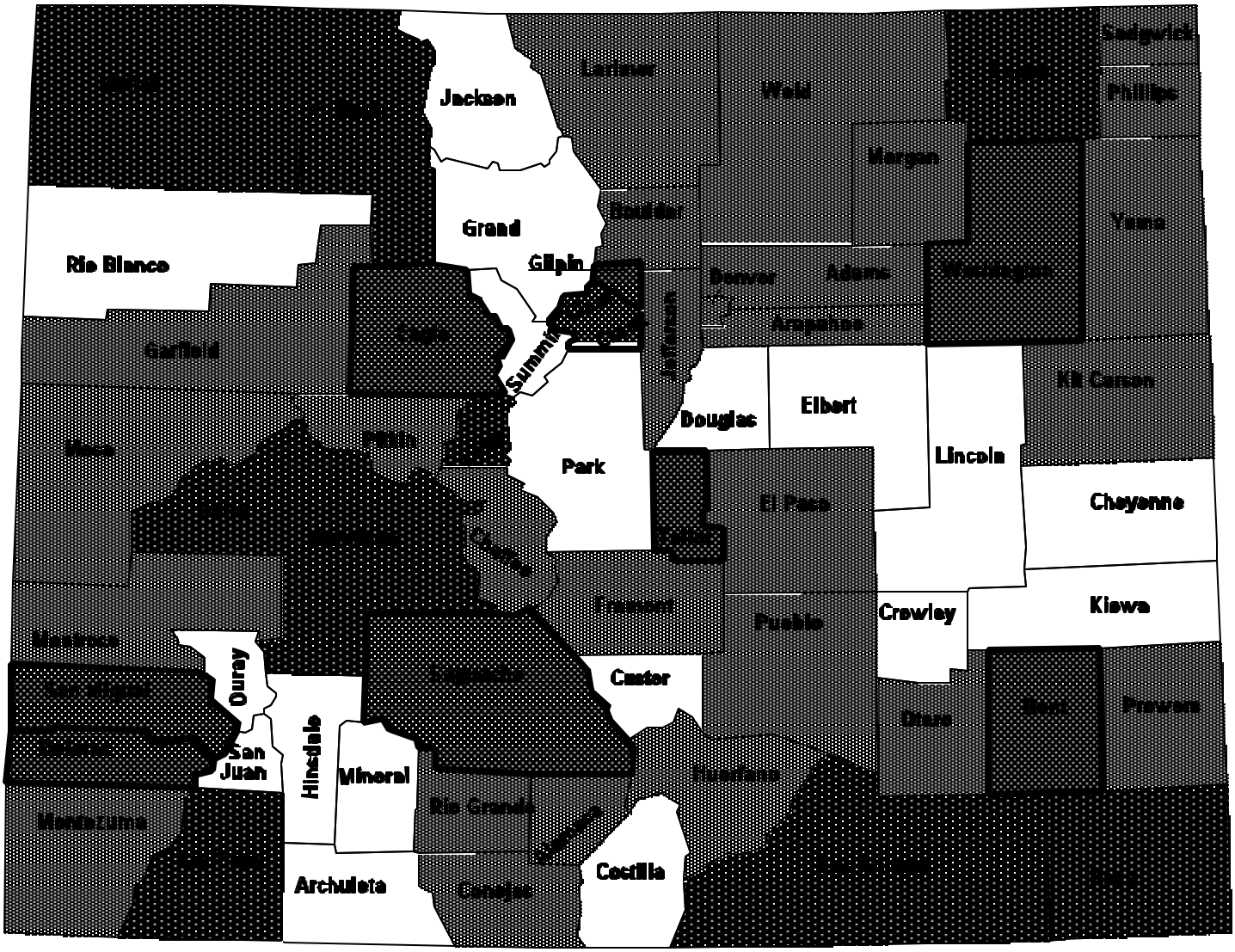
Recommendation No. 18:

The Department of Health Care Policy and Financing should continue efforts to implement effective means for communicating program requirements and changes to providers about the Colorado Indigent Care Program and obtaining provider feedback.

Department of Health Care Policy and Financing Response:

Agree. The Department will continue its efforts to implement effective means for communicating program requirements and changes to the CICP providers. This includes seeking provider feedback and input on program changes. This is an on-going procedure for the Department.

APPENDIX A: CICP Provider Network[1]
Fiscal Year 2002
(68 Providers: 50 Hospitals and 18 Clinics)



Hospitals and clinics (including satellite clinics) participate (27)
Only hospitals participate (9)
Only clinics (including satellite clinics) participate (9)
No CICP provider (18)[2]

Source: Department of Health Care Policy and Financing.
[1]The map does not reflect Broomfield County. There are no CICP providers in Broomfield County for Fiscal Year 2002.
[2]Including Broomfield County, there are 19 counties in Fiscal Year 2002 with no CICP provider.

APPENDIX B: Colorado Indigent Care Program
Payments and Reimbursement Rates[1] for Component 1A Providers Only
Fiscal Years 1999 Through 2001
(Dollars in Millions)

Provider		Fiscal Year		
		1999	2000	2001
Denver Health	Payments based on CICP costs	$32.0	$37.1	$38.9
	Rate	45.0%	46.7%	47.2%
	Payments based on CICP costs, plus bad debt and Major Teaching payments[2]	$56.1	$47.4	$65.0
	Rate	78.9%	59.7%	78.8%
University Hospital	Payments based on CICP costs	$15.0	$18.8	$22.9
	Rate	33.5%	41.5%	52.0%
	Payments based on CICP costs, plus bad debt and Major Teaching payments[2]	$29.4	$29.1	$36.0
	Rate	65.5%	64.2%	81.7%
The Children's Hospital	Payments based on CICP costs	$1.8	$2.8	$3.6
	Rate	70.0%	82.5%	95.7%
	Payments based on CICP costs, plus bad debt payments[2]	$3.4	$2.8	$4.6
	Rate	128.7%	82.5%	123.2%
National Jewish	Payments based on CICP costs	$1.4	$1.8	$1.5
	Rate	94.5%	131.7%	111.3%
	Payments based on CICP costs, plus bad debt payments[2]	$2.3	$1.8	$2.1
	Rate	154.7%	131.7%	153.6%
Platte Valley Regional Medical Center	Payments based on CICP costs	$0.2	$0.7	$1.0
	Rate	14.8%	88.2%	94.7%
	Payments based on CICP costs, plus bad debt payments[2]	$1.2	$0.7	$1.7
	Rate	120.0%	88.2%	154.0%
San Luis Valley Regional Medical Center	Payments based on CICP costs	$0.2	$0.9	$0.9
	Rate	28.2%	91.2%	97.1%
	Payments based on CICP costs, plus bad debt payments[2]	$0.6	$0.9	$1.2
	Rate	73.1%	91.2%	140.8%

APPENDIX B continued: Colorado Indigent Care Program
Payments and Reimbursement Rates[1] for Component 1A Providers Only
Fiscal Years 1999 Through 2001
(Dollars in Millions)

Provider		Fiscal Year		
		1999	2000	2001
Valley View Hospital	Payments based on CICP costs	$0.2	$0.7	$0.2
	Rate	106.1%	93.8%	49.6%
	Payments based on CICP costs, plus bad debt payments[2]	$1.5	$0.7	$0.9
	Rate	710.4%	93.8%	199.7%
St. Vincent General Hospital	Payments based on CICP costs	O/S	O/S	$0.1
	Rate	--	--	52.5%
	Payments based on CICP costs, plus bad debt payments[2]	O/S	O/S	$0.2
	Rate	--	--	137.0%
The Springs Center for Women	Payments based on CICP costs	N/P	$0.2	$0.3
	Rate	--	86.4%	105.6%
	Payments based on CICP costs, plus bad debt payments[2]	N/P	$0.2	$0.3
	Rate	--	86.4%	105.6%
Total: All Component 1A Hospitals				
	Payments based on CICP costs	$50.8	$63.0	$69.4
	Rate	41.6%	47.6%	51.6%
	Payments based on CICP costs, plus bad debt payments[2]	$94.5	$83.6	$112.0
	Rate	77.4%	63.2%	83.3%

Source: Office of the State Auditor analysis of Department of Health Care Policy and Financing data.
Notes:
O/S indicates that the provider was classified as an Outstate Hospital (not a Component 1A Hospital) for the fiscal year listed.
N/P indicates that the provider did not participate in CICP for the fiscal year listed.

[1] Reimbursement rates are calculated as the amount of CICP payments paid by the State to a provider divided by the provider's CICP costs. These costs are not shown in this table.

[2] These payments are not based on CICP costs. Bad debt payments are based on the providers' bad debt from prior years and were made only in Fiscal Year 1999 and Fiscal Year 2001. Major Teaching Hospital payments were made in all three fiscal years shown; only Denver Health and University Hospital qualify as teaching hospitals under the State Plan for the Medicaid program.

The electronic version of this report is available on the Web site of the
Office of the State Auditor
www.state.co.us/auditor

A bound report may be obtained by calling the
Office of the State Auditor
303-866-2051

Please refer to the Report Control Number below when requesting this report.

Report Control Number 1391