Colorado Indigent Care Program Report in Response to the February 2002 *Colorado Indigent Care Program Performance Audit* Concerning the Equity and Calculation Methodology of Provider Payments

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Issued December 1, 2002

December 1, 2002

The Honorable Jack Taylor
Chairperson
Legislative Audit Committee
State Capitol Building
200 E. Colfax Avenue
Denver, CO 80203

Dear Senator Taylor and Members of the Committee:

Subject: Colorado Indigent Care Program Report in Response to the February 2002 *Colorado Indigent Care Program Performance Audit* Concerning the Equity and Calculation Methodology of Provider Payments

Enclosed you will find the requested report that addresses recommendations number one, twelve and thirteen from the *Colorado Indigent Care Program Performance Audit* by the Office of the Colorado State Auditor, issued February 2002. The Department is thankful for the suggestions presented in the performance audit and for the quality work performed by the State Auditor's Office. We hope the Legislative Audit Committee will agree that the proposed methodology described in this report will benefit the hospital-based provider community and increase access to medically necessary care for the indigent population.

We believe the proposed methodology to reimburse Colorado Indigent Care Program providers and disproportionate share hospitals described in the enclosed report creates a single, aligned payment, which distributes the funds in a more equitable manner. This methodology uses data on the medically indigent and Medicaid population to deliver a higher reimbursement to those providers who provide the majority of care given the financial restraints imposed by federal regulations regarding the Disproportionate Share Hospital Limit and the Medicare Upper Payment Limit.

The proposed changes to the distribution of Colorado Indigent Care Program and Disproportionate Share Hospital funds have been approved by the Governor's Office of State Planning and Budgeting. The proposal is included as decision item 6 in the Department's FY 2003-04 budget request and has been included as part of the report for your consideration. Any endorsement the Legislative Audit Committee can provide to achieve approval of the proposed reimbursement methodology and the suggested statutory change is appreciated by the Department.

My staff and I are available to the Committee if you require any further responses regarding the enclosed report. If you have any questions, please contact Chris Underwood, the manager of the Colorado Indigent Care Program (within Safety Net Financing Section) by phone at (303) 866-5177 or by e-mail at Chris.Underwood@state.co.us.

Sincerely,

Karen Reinertson
Executive Director

Enclosure: Colorado Indigent Care Program Report in Response to the February 2002 *Colorado Indigent Care Program Performance Audit* Concerning the Equity and Calculation Methodology of Provider Payments. Issued December 1, 2002

cc: Joanne Hill, State Auditor, Office of the State Auditor
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Barbara Prehmus, Legislative Liaison, HCPF

Introduction

This report addresses the recommendations number one, twelve and thirteen from the *Colorado Indigent Care Program Performance Audit* by the Office of the Colorado State Auditor, issued February 2002.

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.

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.

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.

The Department agreed to submit this report to the General Assembly. This report provides an alternative to the Colorado Indigent Care Program (CICP) current provider reimbursement methodology and links provider payments more directly to the volume of qualified services rendered by providers. The proposed methodology generates a more equitable payment to providers. In addition, the revised methodology aligns the Component 1A and the Outstate prospective payment calculation.

Financing Limits

The federal funding available for distribution by the Department to Colorado Indigent Care Program providers and those providers eligible to receive the federally required Disproportionate Share Hospital payment is restricted by two separate limits: the Disproportionate Share Hospital Limit and the Medicaid Upper Payment Limit. Within these limits, the Department distributed $136,572,000 to providers in FY 2000-01. Approximately 14.1% of these payments consisted of state General Fund, while the remainder was federal funds.

In order to generate federal matching funds without a General Fund contribution, the Department uses Cash Funds Exempt as the state share from certification of public expenditures on Colorado Medicaid services and uncompensated indigent care services. Certification of public expenditures, available only to those facilities owned by a local government entity or the State, is used in place of spending state General Fund as the basis for drawing down federal funds. The Department then passes to facilities the federal matching funds it receives based on the certified expenditures. Certification of public expenditures on Colorado Medicaid services draws federal funds through the Medicare Upper Payment Limit. The certification of public expenditures on uncompensated indigent care services draws federal funds available under the Disproportionate Share Hospital Limit.

The Disproportionate Share Hospital Limit was established by the Balanced Budget Act of 1997, which instituted declining limits on the amount of federal funds available to states for hospitals, which serve a disproportionately high number of low-income patients. For Colorado, under current regulations, the federal funds limits are as follows:

Disproportionate Share Hospital Limit

Federal Fiscal Year	Disproportionate Share Hospital Federal Payment Maximum
1997-98	$93,000,000
1998-99	$85,000,000
1999-00	$79,000,000
2000-01	$81,765,000
2001-02	$83,890,890
2002-03	$75,924,000

Starting in Federal Fiscal Year 2002-03, the limits will be adjusted upward by a cost-of-living factor each year. However, federal legislation was enacted in September 2000 that maintains the Federal Fiscal Year 1999-00 allotment of $79,000,000 for Federal Fiscal Years 2000-01 and 2001-02 plus increases tied to a CPI-U index for those years. The allotment for Federal Fiscal Year 2000-01 was $81,765,000 and $83,890,890 for Federal Fiscal Year 2001-02. Starting in Federal Fiscal Year 2002-03, under current law, the Disproportionate Share Hospital allotment will revert to the Balanced Budget Act of 1997 law that indicates the Colorado allotment will be $74,000,000 plus an inflationary increase. Assuming an inflationary increase of 2.6%, the Federal Fiscal Year 2002-03 allotment would be $75,924,000. It is possible that additional federal legislation could be enacted to change the Federal Fiscal Year 2002-03 Disproportionate Share Hospital allotment. Currently, such legislation is gaining support in the U.S. House of Representatives, but as of this writing it remains in the Committee on Energy and Commerce.

The Medicare Upper Payment Limit is the maximum the State Medicaid program can reimburse providers and still receive a federal match. The Medicare Upper Payment Limit must be a reasonable estimate under current conditions; it does not represent actual Medicaid reimbursement for the request year, Medicaid provider costs, or potential Medicare reimbursement. Medicaid reimburses providers below this limit, which provides an opportunity for the State to use certification of public expenditures and send more federal funds to providers. The difference between the upper payment limit and what Medicaid reimbursed providers is available for certification and the State receives the federal match rate on this amount.

In addition, the Medicare Upper Payment Limit restricts the amount of funds available depending on provider ownership. The Medicare Upper Payment Limit has three categories: privately owned, locally (county and city) owned, and state owned. The Department primarily utilizes the Medicare Upper Payment Limit for publicly and state

owned facilities, since certification of public expenditures is only available for these providers. Reimbursement under the Medicare Upper Payment Limit for privately owned facilities requires a General Fund match.

Current Reimbursement Methodology

This report does not attempt to describe the detail or mathematics of the current reimbursement methodologies. The information is provided to demonstrate the complex system that has developed over the years to maximize revenue to the provider community while minimizing the General Fund expenditures.

Currently, the Department distributes the federal funds covered under Disproportionate Share Hospital limit by the following payment methodologies:

- Pre-Component 1 Payments
- Component 1A Payments
- Bad Debt Payments
- Payments to Outstate Hospital CICP Providers

To fulfill the federal requirement that states make enhanced payments for those "safety net" hospitals which provide services to a disproportionate share of Medicaid and low-income patients, Colorado made disproportionate share payments called **Pre-component 1 payments**. These payments are made to any Colorado Medicaid hospitals that meet the following criteria:

1. Have a Medicaid inpatient utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or a low income utilization rate that exceeds 25 percent.
2. A hospital must have at least two obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services under the State Plan.

Federal Medicaid regulations require that states provide additional compensation to hospitals meeting these minimum criteria. The requirements on the amount of payments a state can make are not specified by the federal regulations. The payments are funded with General Fund and federal funds, subject to the federal match rates.

Component 1A payments are made to hospitals that meet the following criteria:

1. Have a Medicaid inpatient utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or a low income utilization rate that exceeds 25 percent.
2. A hospital must have at least two obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services under the State Plan.

3. Participate in the Colorado Indigent Care Program (CICP).

These payments are based on reimbursement of Colorado Indigent Care Program write-off uncompensated costs. Payments to Denver Health and University Hospital consist entirely of federal funds, by using the certification of public expenditures for the costs of care provided to indigent clients. Payments to the other qualifying providers are financed with General Fund and federal funds.

A **Bad Debt payment** can be made to any providers who meet the following criteria:

1. Have a Medicaid inpatient utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or a low income utilization rate that exceeds 25 percent.
2. A hospital must have at least two obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services under the State Plan.
3. Participate in the Colorado Indigent Care Program (CICP).
4. Providers must report bad debt to the Colorado Health and Hospital Association for its Annual Report.

A Bad Debt payment is only made if there is room under the federal Disproportionate Share Limit after all other payments covered under this cap have been made. The goal with this payment is to maximize federal dollars, while minimizing General Fund expenditures. All General Fund was removed from the payment in State Fiscal Year 1999-00, by using the certification of public expenditures on unpaid debt from self-pay clients. All payments are made directly to Denver Health and University Hospital, who then voluntarily distribute some of the payment to private hospitals. This distribution is necessary since certification of public expenditures is limited to only government owned facilities, while Denver Health and University wish to maintain equality between providers.

Payments to Outstate hospital CICP providers are made to a provider who meets the following requirements:

1. These hospitals are defined as those hospitals which meet the Disproportionate Share hospital criterion of having a Medicaid inpatient hospital services patient days utilization rate of at least one percent, but do not qualify for any other Disproportionate Share Hospital reimbursement such as Pre-component 1 Payments, Component 1A payments or bad debt payments.
2. A hospital must have at least two obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services under the State Plan.
3. Participate in the Colorado Indigent Care Program (CICP).

The payment is proportionately allocated to providers based on the anticipated utilization of Colorado Indigent Care Program services. Annually, the Colorado General Assembly appropriates an amount of money for Colorado Indigent Care Program Outstate providers. At the beginning of each fiscal year, providers submit estimated total annual charges for providing care to eligible CICP patients. Total charges reduced by estimated third party payments and patient liability determines estimated write-off charges. Write-off charges are converted to estimated costs by applying each provider's cost-to-charge ratio to write-off charges. The Outstate appropriation divided by the sum of all providers' estimated write-off costs determines the CICP reimbursement percentage. This percentage is applied to each provider's costs to determine the estimated annual reimbursement. Disproportionate Share Hospital payments are made to both publicly and privately owned hospitals, but the total reimbursement has been capped at 30% of costs associated with servicing the CICP population.

As noted in the *Colorado Indigent Care Program Performance Audit*, the Department uses two different methodologies for calculating the reimbursement to Outstate providers and to Component 1A providers even though the payments are for the same CICP population. Notably the patient payment percentages, which adjust providers' total patient liability in the Component 1A payment, were considered outdated and inaccurate by the state auditor.

Currently, the Department distributes the Medicare Inpatient Upper Payment Limit by the following payment methodologies:

- Major Teaching Hospital
- Payments to Outstate hospital CICP Providers

A Colorado hospital qualifies as a **Major Teaching Hospital** when its Medicaid days combined with indigent care days (days of care provided under the Colorado Indigent Care Program) equal or exceed 30% of its total patient days for the prior state fiscal year, or the most recent year for which data are available. In addition, a Major Teaching Hospital must fulfill the following criteria:

1. Maintains a minimum of 110 total Intern and Resident Full Time Equivalents (FTEs).
2. Maintains a minimum ratio of .30 Intern and Resident FTEs per licensed bed.
3. Meets the Department's eligibility requirement for disproportionate share payment.

Denver Health, University Hospital and the Children's Hospital, by virtue of their status as teaching hospitals and the disproportionate share of care they provide to low-income patients are eligible for these enhanced Medicaid Payments.

The **payment methodology for Outstate hospitals** is the same as previously described under the Disproportionate Share Hospital Limit, but Upper Payment Limit payments are made only to publicly owned hospitals. The total reimbursement which includes Upper Payment Limit payments and Disproportionate Share Hospital payments has been capped at 30% of costs associated with servicing the medically indigent population.

Proposed Reimbursement Methodology

After much consideration, the Department decided to continue to base the reimbursement on indigent care costs reported by providers, but allow the volume of Medicaid and indigent care patients served by the provider to influence what percentage of indigent care costs were reimbursed. This new reimbursement replaces the methodologies for rate setting for the Major Teaching Hospitals, Outstate Indigent Care Program, Disproportionate Share Payments to Hospitals, Pre-Component 1 Disproportionate Share Payments to Hospitals and Bad Debt. The primary goal in combining the methodologies was to create a more simplified system that can be generally understood by Department staff and providers, and which applies the reimbursement methodology consistently to all providers within each provider category. Another goal was to make the calculation dependent on information available for the November 1 budget submission to reduce the number of Supplemental and Budget Request Amendments associated with these payments. Further, the rate setting process was optimized to maximize the federal funds available and minimize the General Fund necessary in the system, while equitably distributing the pool of money to providers who served a disproportionate number of Medicaid and low-income clients.

In addition, this methodology utilizes the Medicare Upper Payment Limit for private facilities. This allows the Department to shift payments from the Disproportionate Share Hospital Limit to the Medicare Upper Payment Limit and increase the reimbursement to publicly owned providers. Since certification of public expenditures is available to publicly owned providers, their reimbursement will increase and no increase in General Fund is required.

Further, the traditional method of capping Outstate Hospital provider payments at 30% of costs associated with servicing the medically indigent population is terminated. The new reimbursement methodology for Outstate Hospital providers raises their reimbursement rate beyond the traditional cap of 30% of costs, with no extra General Fund expenditure.

The initial calculations under the proposed reimbursement methodology demonstrate a more equitable distribution of funds. A privately owned hospital, which provides 14.5% of total days to Medicaid and 5.1% of total days to indigent care, receives approximately 48.2% reimbursement on indigent care costs. A publicly owned hospital, which provides 14.4% of total days to Medicaid and 2.8% of total days to indigent care, receives a slightly lower reimbursement (approximately 47.8%) on indigent care costs, since they provide fewer total days to the medically indigent population. Under the current methodology, both these providers would have received 30% reimbursement on indigent

care costs. The proposed methodology allows Denver Health and University to receive the highest reimbursement on indigent care costs (approximately 61.9%), since they provide the largest percentage of Medicaid and indigent care days. These figures are only estimates based on the data used to set the FY 2002-03 provider reimbursement. The percent of indigent care costs reimbursed for each provider will change for FY 2003-04.

Currently five different appropriated line items in the Department's budget are managed to distribute Disproportionate Share Hospital Limit and Medicare Upper Payment Limit funds. The Department's request is that all the line items would be combined into a single line item. There would be only three separate calculations or payments: Low-Income Safety-Net Provider payment (or just Low-Income payment), High-Volume Safety-Net Provider payment (or just High-Volume payment) and Medicaid Shortfall payment. The Low-Income payment and the High-Volume payment use virtually the same formula to distribute different pools of funds. These two payments are discussed at length below. The **Medicaid Shortfall payment** is a simplified payment to providers who qualify for a Disproportionate Share Hospital payment under the federal guidelines, but do not participate in the Colorado Indigent Care Program. Only two providers are expected to receive this payment in FY 03-04.

The **Low-Income payment** is an allocation of the available Disproportionate Share Cap. The Disproportionate Share Cap would be distributed by the facility-specific Weighted Medically Indigent Costs relative to the sum of all the Weighted Medically Indigent Costs. This calculation is separate for publicly owned and privately owned providers, since the two groups have unique pools of money.

The **High-Volume payment** is an allocation of the available upper payment limit remaining for certification of public expenditures. There would be three allotments of the upper payment limit: State Owned Providers, Local Government Owned Providers and Privately Owned Providers. The amount of available federal funds is distributed by the facility-specific Weighted Medically Indigent Costs relative to the sum of all the Weighted Medically Indigent Costs. This calculation would be separate for state owned, local government owned, and privately owned providers, since the three groups have unique pools of funds.

The general calculation process would be virtually the same for the Low-Income and High-Volume payments and is outlined as follows:

1. Available medically indigent costs, as reported in the most recent Colorado Indigent Care Program annual report, would be inflated forward to the request budget year using the Consumer Price Index - Urban Wage Earners, Medical Care Index - Denver as of July.
2. The request budget year medically indigent costs would then be weighted by the following factors to measure the relative Medicaid and low-income care to total care provided. Each provider would have its request budget year medically indigent costs inflated by the following factors:

a. Percentage of Medicaid fee-for-service and managed care days relative to total inpatient days. Both variables are published by the Colorado Health and Hospital Association. This percentage is not allowed to exceed one standard deviation above the mean.

b. Percentage of medically indigent days relative to total inpatient days. Inpatient days are published by the Colorado Health and Hospital Association and medically indigent days are reported in the Colorado Indigent Care Program annual report. This percentage is not allowed to exceed one standard deviation above the mean.

3. The request budget year medically indigent costs would also be weighted by the following factors, if they qualify, to measure the relative Medicaid and low-income care to total care provided. If the provider qualifies, the provider would have its request budget year medically indigent costs further inflated by the following factors:

    a. Disproportionate Share Hospital Factor. To qualify for the Disproportionate Share Hospital Factor, the provider must have its percentage of Medicaid days relative to total days exceed one standard deviation above the mean.

        i. If the provider does qualify, then the Disproportionate Share Hospital Factor would equal the provider specific percentage of Medicaid days relative to total inpatient days. Both variables are published by the Colorado Health and Hospital Association. This percentage is not allowed to exceed one standard deviation above the mean.

        ii. If the provider does not qualify, then the Disproportionate Share Hospital Factor would equal one, or have no impact on request budget year medically indigent costs.

    b. Medically Indigent Factor. To qualify for the Medically Indigent Factor, the provider must have its percentage of medically indigent days relative to total inpatient days exceed the mean.

        i. If the provider does qualify, then the Medically Indigent Factor would equal the provider specific percentage of medically indigent days relative to total inpatient days. Inpatient days are published by the Colorado Health and Hospital Association and medically indigent days are reported as inpatient additions in Colorado Indigent Care Program annual report. This percentage is not allowed to exceed one standard deviation above the mean.

        ii. If the provider does not qualify, then the Medically Indigent Factor would equal one, or have no impact on request budget year medically indigent costs.

4. High-Volume payment: The available federal funds under the Medicaid Upper Payment Limit would be multiplied by the hospital specific Weighted Medically Indigent Costs divided by the summation of all Weighted Medically Indigent Costs to calculate the High-Volume payment for the specific provider. The available Upper Payment Limit for private, local and state owned providers will be distributed within each group.
5. Low-Income payment: The available federal funds would be multiplied by the hospital specific Weighted Medically Indigent Costs divided by the summation of all Weighted Medically Indigent Costs to calculate the Low-Income payment for the specific provider.
    a. The available Disproportionate Share Hospital Cap for privately owned providers would be equal to 1% of the General Fund appropriated to the new Safety-Net Provider Payments line item. All qualifying providers are required to receive a Disproportionate Share Hospital payment under federal regulations, so a portion of Disproportionate Share Hospital Cap must be used for privately owned providers.
    b. The available Disproportionate Share Hospital Cap for publicly (local and state) owned providers equals the Disproportionate Share Cap imposed by the Centers for Medicare and Medicaid Services minus other federal funds designated as a Disproportionate Share Hospital payment under a separate State Plan and the amount of the federal funds distributed to the privately owned providers.

The proposed changes to distribution of Colorado Indigent Care Program and Disproportionate Share Hospital funds described above have been approved by the Governor's Office of State Planning and Budgeting. The proposal is included as decision item 6 in the Department's FY 2003-04 budget request and has been enclosed with this report for your consideration.

To accomplish this new methodology, the Department requests a single appropriation line titled Safety-Net Provider Payments. This line item would combine the current five line items into a single line item. The current line items are as follows:

Department of Health Care Policy and Financing
(4) Indigent Care Program

Denver Indigent Care Program

University Hospital Indigent Care Program

Out-state Indigent Care Program

Disproportionate Share Payments to Hospitals

Pre-Component 1 Disproportionate Share Payments to Hospitals

Currently the statute governing the Colorado Indigent Care Program, the "Reform Act for the Provision of Health Care for the Medically Indigent" states,

> 26-15-106 (6)(b), C.R.S. The contract amounts for the provision of services to the medically indigent shall be those identified in the general appropriation bill as follows: The Denver indigent care program; the out-state indigent care program and the specialty indigent care program; the university hospital indigent care program; and indigent care program administration.

This language could obstruct the General Assembly's ability to combine the current five appropriation items into a single line item. If the Legislative Audit Committee elects to seek the statutory changes as outlined in the Colorado Indigent Care Program Performance Audit, the Department respectfully requests that 26-15-106 (6)(b) be repealed.

As noted in the Interim Report dated September 13, 2002 it is the Department's intent to request additional statutory changes beyond those listed in the audit report to clarify the programmatic and financing structure of the Colorado Indigent Care Program.

CICP Provider Auditing

As noted in the Colorado Indigent Care Program Performance Audit, the administrative oversight of the program must be improved if the Department decided to continue to use indigent care costs derived from indigent care charges in the reimbursement calculation. The program has strengthened the Colorado Indigent Care Program Provider Compliance Audit requirements to better insure that indigent care charges are accurate and allowable. The revised provider compliance audit requirements were effective July 1, 2002.

As suggested in the performance audit, the provider audit has been revised on a risk-based assessment. Only those providers who received more than $500,000 in reimbursement are required to hire an independent, external auditing firm to perform the provider audit. Eighteen providers, or 27% of the CICP providers, are required to hire an independent auditing firm. These providers represent 94.6% of the funding the Department paid to all CICP providers. Only five of the fifteen community health centers, are required to hire an independent auditing firm. The remaining providers are still required to perform an annual compliance audit, but can perform the audit using internal staff. Overall, this should prove less of a financial burden on the providers participating in CICP, many of which can now perform the less costly internal provider audit.

The eligibility audit and billing audit have been broken into two distinct sections, each using a separate sample size. Both sections will use a minimum sample size

of 25 records. The eligibility section of the audit now requires that the sample consist only of client applications completed by the provider. Providers are not required to obtain or test applications completed at another facility. The billing section of the provider audit examines billing records submitted by the provider to the program and the same size is selected independently from the eligibility audit sample, unless the sample size is so small that all client records must be used for both audits.

The provider audit now contains a standardized form that providers shall use for reporting the audit results. If the audit does not comply with this template, the audit will be found out of compliance. The form delineates all areas that need to be reported and will ensure that all requirements are tested. In addition, the form will allow the Department to easily verify which attributes of the audit were compliant or noncompliant.

In the previous provider compliance audit requirements, only two of the nine attributes were related to charges, and there were no attributes that tested the actual charge itself. In the revised audit requirements, there are eight attributes that relate to the billing records and the actual charge is tested. Also new to the audit requirements is a distinct billing section, which examines the billing records submitted to the program. One attribute specifically requires that the total charge for the service was the same charge billed to other patients, not on the Colorado Indigent Care Program, during the same period. Another attribute requires the auditor to verify that the billing record information, including billed charges, reimbursement due from third parties, and client copayment was correctly translated into the summary billing submitted to the program. In addition, the programmatic section of the audit requires the auditor to verify that detailed client billing records exist to support all summary information submitted to the program.

The provider compliance audit requirements have been updated to reinforce the established policy that providers maintain the detail data to substantiate all amounts reported to the Department as a basis for reimbursement, including those for contractual services, for a period of five state fiscal years. This is noted in numerous sections in the FY 2003 CICP Manual and the provider audit directly tests this requirement.

The Department implemented new procedures July 1, 2002 to improve the internal monitoring of provider compliance audits, by creating a Microsoft Access database to log and track all the audits. This database has the functionality to log when provider audits arrive; generate reports stating which audits have been received and which are overdue; generate standardized letters to notify providers that an audit is required and not received by the program's administration; generate detailed letters noting the attributes for which the provider was out of compliance and request a corrective action plan; and provide more flexibility and uniformity for the program's administration to monitor the

provider compliance audits. With these details available and computerized, the program can better assess when to withhold payments or eliminate providers from the program in cases when a provider does not fully comply with the audit requirements.

The Department lacks the resources available to perform any on-site audits or to contract with a public accounting firm to perform on-site audits for the program. The Department continues to examine this issue. In the provider audit requirements, a CICP Administrative Audit was established. All providers are subject to an audit by the CICP administration or agent of the program. The CICP administration would notify the provider 60 days prior to conducting this audit. At that time, the scope and criteria of the audit would be identified. Due to the lack of resources, no CICP Administrative Audits are currently scheduled for FY 2003.

As noted in the performance audit, the cost-to-charge ratio used to convert provider submitted charges to costs was not consistently calculated. To rectify this situation, the Department has contracted with the current Medicaid Hospital and Federally Qualified Health Center Auditor, to develop a medically indigent specific cost-to-charge ratio. This will provide the program audited information on which to base the provider's cost-to-charge ratio and assist in applying the reimbursement methodology consistently to providers within each provider category. The Department expects to obtain the medically indigent specific cost-to-charge ratio information for setting the FY 2003-04 provider rates.

CICP Clinic Reimbursement

This report detailed a change in the reimbursement methodology for hospital providers which provide medical care to the indigent population, not the clinic providers who provide medical care to the same population. The clinic providers, which are primarily community health centers, who participate in the Colorado Indigent Care Program provide numerous services including primary and preventive care. Under the 26-15-106, C.R.S., the Department is instructed to provide emergency care as the foremost priority and all other medically necessary care as lower priority.

> 26-15-106 (9)(b) Such medical services shall be prioritized in the following order:
>
> (I) Emergency care for the full year;
>
> (II) Any additional medical care for those conditions the state department determines to be the most serious threat to the health of medically indigent persons;
>
> (III) Any other additional medical care.

The reimbursement to these clinic providers has been capped at not more than 30% of costs and is subject to the availability of General Fund. The new methodology proposed in this report does not alter the reimbursement to clinic providers, nor does it request any change to the line item appropriation for this provider group. A yearly General Fund increase would be required for the reimbursement to the clinic providers to remain at 30% of costs for FY 2003-04. The Department continues to examine the role of clinics in the program and is considering statutory changes to clarify discrepancies noted in the *Colorado Indigent Care Program Performance Audit*.

Conclusion

In conclusion, the new methodology to reimburse Colorado Indigent Care Program providers and disproportionate share hospitals described in this report creates a single, aligned payment, which distributes the funds in a more equitable manner. This methodology uses data on the medically indigent and Medicaid population to deliver a higher reimbursement to those providers who provide the majority of care within the Disproportionate Share Hospital Limit and the Upper Payment Limit. The Department is thankful for the suggestions presented in the Colorado Indigent Care Program Performance Audit and the quality work performed by the State Auditor's Office.

The Department hopes that the Legislative Audit Committee agrees that the proposed methodology described in this report will benefit the hospital-based provider community and increase access to medically necessary care for the indigent population.