Medicaid Hospital Provider Fee Program

Department of Health Care Policy and Financing

Performance Audit
September 2012

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STATE AUDITOR

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Office of the State Auditor

Dianne E. Ray, CPA
State Auditor

September 19, 2012

Members of the Legislative Audit Committee:

This report contains the results of a performance audit of the Medicaid Hospital Provider Fee Program. The audit was statutorily required and conducted pursuant to Section 2-3-119, C.R.S., which required the State Auditor to conduct a performance audit of the hospital provider fee established pursuant to Section 25.5-4-402.3, C.R.S. The State Auditor was required to conduct a performance audit of the hospital provider fee in the second year of the program, and additional audits may be conducted at the discretion of the State Auditor. The report presents our findings, conclusions, and recommendations, and the responses of the Department of Health Care Policy and Financing.

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Glossary of Terms and Abbreviations

Act – Colorado Health Care Affordability Act

Advisory Board – Hospital Provider Fee Oversight and Advisory Board

Cash Fund – Hospital Provider Fee Cash Fund

C.F.R. – Code of Federal Regulations

CHP+ – Child Health Plan Plus Program

CICP – Colorado Indigent Care Program

CMS – U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services

Department – Colorado Department of Health Care Policy and Financing

DSH payment – Disproportionate Share Hospital payment

Expansion population – Colorado residents covered by the State medical assistance program as part of the expanded Medicaid eligibility under the Colorado Health Care Affordability Act

HCRIS – Medicare Cost Reports in CMS's Healthcare Cost Report Information System

MMIS – Colorado Medicaid Management Information System

Program – Medicaid Hospital Provider Fee Program

Provider Fee Model – Hospital Provider Fee Model

Recovery Act – American Recovery and Reinvestment Act

Supplemental Payments – Payments made to hospitals as part of the Colorado Health Care Affordability Act to reimburse them for providing medical care under the State medical assistance program and CICP

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MEDICAID HOSPITAL PROVIDER FEE PROGRAM

Performance Audit, September 2012
Report Highlights

Dianne E. Ray, CPA
State Auditor

Department of Health Care Policy and Financing

PURPOSE

Evaluate the Hospital Provider Fee Program to determine the Program's compliance with federal and state laws, and assess the reliability of data used in the Hospital Provider Fee Model to calculate the fees paid by hospitals and supplemental payments made to hospitals.

BACKGROUND

- House Bill 09-1293, the Colorado Health Care Affordability Act, allowed the Department to implement the Hospital Provider Fee Program and to assess fees on all licensed or certified hospitals in the state.
- Hospital provider fees are used to increase reimbursement to hospitals for providing care under the State medical assistance program, increase the number of individuals eligible for the State medical assistance program, and cover the state's administrative expenses for implementing the Program.

OUR RECOMMENDATIONS

The Department should:

- Improve the accuracy, reliability, consistency, and oversight of the data used to determine hospital provider fees and supplemental payments.
- Provide the Advisory Board with quarterly updates on the expansion population expenditures to ensure that hospital provider fees collected do not significantly exceed the amount needed to support the expansion population expenditures.
- Restrict user access to the Provider Fee Model spreadsheet by eliminating users who do not have a business need to access the spreadsheet and add a method to track changes in the spreadsheet.

The Department agreed with all recommendations.

AUDIT CONCERN

The Department should ensure the Hospital Provider Fee Model is based on accurate, consistent, and reliable data, and should work with the Advisory Board to ensure it does not collect significantly more in provider fees than is needed to fund the Program each year.

KEY FACTS AND FINDINGS

Overall, the Department's administration of the Program is in compliance with applicable federal and state laws. We identified the following improvements the Department and the Advisory Board could make to better achieve the Program's goals.

- The Department relies, in part, on self-reported hospital data to determine the hospital provider fees hospitals must pay and the supplemental payments hospitals receive each year. These self-reported hospital data are not always accurate, consistent, or reliable. In one case, inaccurately reported data resulted in a hospital receiving a supplemental payment of $428,200 that it should not have received. Additionally, 24 (45 percent) of the 53 data points self-reported by hospitals varied by greater than 10 percent from the same data points reported in audited Medicare cost reports. Finally, three (30 percent) of the 10 hospitals in our sample could not provide supporting documentation for one or more of the 221 data points reported in one or more years.
- The Department collected significantly more in hospital provider fees than it needed to fund the Program during the first two Model years. The majority of the overcollections in the first two years are attributable to the Department's overestimation of the amount of provider fees needed to fund the expansion populations. The Department collected $25.6 million and $13 million more in fees to pay for expansion services than it spent on the expansion population in Model Years 1 and 2, respectively. Model Year 3 will not be complete until September 30, 2012; however, the Department estimated expansion costs of $105.4 million for Model Year 3 and as of June 30, 2012, which represents three quarters of Model Year 3, it had expended approximately $50.3 million for the expansion populations.
- The Department does not have adequate controls to restrict unnecessary user access to the Provider Fee Model spreadsheet to ensure that the calculations and data in the Provider Fee Model are sufficiently controlled. Specifically, 12 Department staff, with no business need to access the Provider Fee Model spreadsheet, have full access to the spreadsheet. In addition, the Department does not have a method for tracking changes in the spreadsheet used for the Provider Fee Model.

For further information about this report, contact the Office of the State Auditor
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Medicaid Hospital Provider Fee Program

Overview

Medicaid, or Title XIX of the Federal Social Security Act, is a federal-state partnership financed jointly by state and federal funding to provide health care coverage to low-income individuals. The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), administers federal Medicaid programs. The Department of Health Care Policy and Financing (the Department) administers the public health insurance programs for Colorado residents. One of the public health insurance programs is the State medical assistance program, which is Colorado's Medicaid program. Eligibility for the Medicaid program is determined by family size, income, and the age of the individual. As a condition for receipt of federal Medicaid funds, the Department must submit a State plan for the State medical assistance program to CMS and agree to administer the program in accordance with the provisions in the State plan. Finally, states are paid the federal share of Medicaid on a reimbursement basis and each year, the federal government publishes the Federal Medical Assistance Percentages that determine the amount of federal matching funds each state is reimbursed for their state medical assistance programs.

States typically use funding from their general fund to match the federal Medicaid funds. However, federal Medicaid laws also permit states to impose health-care-related taxes, or fees, on providers of health care services, and states can use those fees to access federal Medicaid matching funds. While the federal law prohibits health care providers from directly shifting the provider fee to their clients or insurers, the law provides flexibility in terms of how the fee is assessed. States may determine the type of fee that will be assessed, as well as how the funds collected will be used. More than 40 states currently have health care provider fees, and 20 states have provider fees specific to hospitals.

Because Colorado hospitals were providing a large amount of uncompensated care and the Medicaid reimbursement rates were not enough to cover hospitals' cost of providing services, in 2008, the State began to explore the possibility of implementing a hospital provider fee in Colorado so it could access additional federal matching funds and increase reimbursements to hospitals. In 2009, House Bill 1293, the Colorado Health Care Affordability Act (the Act), was enacted as part of Colorado's comprehensive health care reform to reduce the costs of

uncompensated care to hospitals and expand health care coverage to Colorado residents. The Act established the Medicaid Hospital Provider Fee Program (the Program). In accordance with the Act, Section 25.5-4-402.3, C.R.S., authorizes the Department to charge and collect hospital provider fees from all licensed or certified hospitals in the State. According to Section 25.5-4-402.3(4), C.R.S., the revenue generated from the hospital provider fees should be used to:

- Increase reimbursement to hospitals for providing medical care under the State medical assistance program and the Colorado Indigent Care Program (CICP). We refer to these reimbursements as "supplemental payments."

- Increase the number of individuals covered by the State medical assistance program and the Child Health Plan Plus (CHP+) program. The Department estimated that eligibility for these programs would expand by more than 100,000 Coloradans upon complete implementation of the Hospital Provider Fee Program. We refer to these individuals as the "expansion population."

- Pay for the Department's administrative costs of implementing the Program. We refer to these costs as "administration."

In 2011, the General Assembly passed Senate Bill 11-212, which allowed for the hospital provider fees to offset existing general fund Medicaid expenditures in the amount of $50 million in State Fiscal Year 2012 and $25 million in State Fiscal Year 2013.

Before the State could implement the Program, the Department had to apply for a waiver from CMS for two of the three federal requirements pertaining to provider fees. To impose a provider fee, states must meet the following three requirements: (1) the fees must be *broad-based*, meaning they are applied to all providers in the jurisdiction; (2) the fees must be *uniform*, meaning the same amount is charged to all the providers; and (3) the fee structure may not violate the hold-harmless provision of the law, meaning states may not create a mechanism to ensure providers that pay fees are repaid for all or a portion of the fees they were charged [42 C.F.R. 433.68(f)]. States may apply for a federal waiver from CMS for the broad-based and uniform requirements, but they must adhere to the hold-harmless provision of the law. To obtain a waiver, states must demonstrate compliance with 42 C.F.R. 433.68(e), which requires the state to show that the net impact of the fee is generally redistributive, or that the fee is not overburdening one hospital or group of hospitals. In March 2010, CMS approved the Department's request to waive the uniform and broad-based requirements for a hospital provider fee. In doing so, CMS approved the specific hospital provider fee structure for Colorado, and the waiver is valid indefinitely unless the Department changes how the

hospital provider fees are structured. In that case, the Department would need to seek a new waiver.

Hospital Provider Fee Program Oversight

In accordance with the Act, the Department and a 13-member Hospital Provider Fee Oversight and Advisory Board (Advisory Board) are responsible for the implementation of the Program, and the Medical Services Board, further described below, is responsible for promulgating rules pertaining to the Program. The roles and responsibilities for the entities charged with overseeing the Program are described below:

The **Department** is responsible for administering the Program by providing expertise to the Advisory Board, preparing and presenting proposed rule changes to the Advisory Board and to the Medical Services Board, calculating the fee and assessing the fee as established in rule by the Medical Services Board, calculating and making the hospital payments, and administering the public health care expansion programs.

The **Advisory Board** is appointed by the Governor with the advice and consent of the Senate and consists of 13 members with no more than six Advisory Board members being members of the same political party. Advisory Board members should include five hospital employees, a representative of a statewide organization of hospitals, a representative from a statewide organization of health insurance carriers, one member of the health care industry who does not represent a hospital or a health insurance carrier, one member who is a consumer of health care, a representative of persons with disabilities, a representative of a business that purchases or provides health insurance for its employees, and two Department employees. The Advisory Board meets regularly throughout the year to provide oversight and make recommendations to the Department and the Medical Services Board on the implementation of the Program. According to Statute [Section 25.5-4-402.3(6)(e), C.R.S.], the Advisory Board must:

- Recommend to the Department the timing and method for assessing the hospital provider fee and the amount of the fee.
- Recommend to the Department the schedule and approach to the implementation of expanding Medicaid eligibility to the expansion populations.
- Recommend changes in the hospital provider fee that increase the number of hospitals benefitting from the fee.
- Recommend to the Department changes to Medicaid inpatient and outpatient payments and quality incentive payments to increase hospital accountability.

- Monitor the impact of the fee on the health care marketplace.
- Provide an annual report on the Hospital Provider Fee Program by January 15 of each year to the Health and Human Services Committees and the Joint Budget Committee of the General Assembly, the Governor, and the Medical Services Board.
- Consult with legislative committees on any legislation that may impact the hospital provider fee or hospital reimbursements.

The **Medical Services Board** consists of 11 members with at least one member from each congressional district and no more than six members from the same political party. Medical Services Board members are appointed by the Governor and confirmed by the Senate. The Medical Services Board has the authority to adopt rules that govern the Department's programs including those related to the implementation of the Act. Specifically, the Medical Services Board is responsible for promulgating rules for the calculation, assessment, and timing of the hospital provider fee; determining the reports the hospitals are required to provide to the Department; and establishing other rules as necessary to implement the Program. In doing so, the Medical Services Board considers recommendations from the Advisory Board for the provider fees and payments to hospitals each year.

Hospital Provider Fee Model

The Act required the Department to create a method to calculate the fees charged to hospitals and the resulting use of those fees for reimbursements paid to hospitals (supplemental payments), increasing the number of individuals covered under the State's Medicaid program (expansion population), and administration of the Program. The Department created the Hospital Provider Fee Model (Provider Fee Model) using custom formulas in a spreadsheet with the statutory and regulatory requirements for the fees and supplemental payments built into it. The current Provider Fee Model contains two fees, an inpatient fee and an outpatient fee, charged to hospitals. Pursuant to the Act, not all hospitals pay a fee and some pay a reduced fee. The Provider Fee Model also contains 13 different supplemental payments to hospitals. Hospitals receive only the supplemental payments that they are eligible for under the terms of the Provider Fee Model for that year.

Department staff designed the original Provider Fee Model in Fiscal Year 2010 with feedback from the Advisory Board. Each year, the Department revises the Provider Fee Model based on input from the Advisory Board and updated hospital data. The Department collects data specific to each hospital and enters it into the Provider Fee Model in order to calculate the hospital provider fees assessed and supplemental payments paid to each hospital. Once the Advisory Board and Medical Services Board approve the Provider Fee Model, the fees and

supplemental payments are established for the year and hospitals in the state are notified of their fee and supplemental payment amounts.

Finally, it is important to note that while the first Provider Fee Model (Model Year 1) was designed to cover State Fiscal Year 2010 (July 1, 2009–June 30, 2010), it was extended to September 30, 2010, to align with the federal fiscal year. The second Provider Fee Model (Model Year 2) was designed to cover Federal Fiscal Year 2011 (October 1, 2010–September 30, 2011), and the third Provider Fee Model (Model Year 3) was designed to cover Federal Fiscal Year 2012 (October 1, 2011–September 30, 2012).

Expansion Populations

In addition to reimbursing hospitals for the cost of uncompensated care through supplemental payments, the goal of the Act is to expand Medicaid and CHP+ program eligibility. The Department estimated eligibility for these programs would increase to more than 100,000 Coloradans upon complete implementation of the Program. The Program is designed to phase in Medicaid eligibility to the expansion populations outlined in the Act over the first several years of the program. As of Fiscal Year 2012, approximately 45,000 additional Colorado residents have been enrolled in Medicaid programs as a result of the Act. The Department is continuing to roll out new expansion populations each year. Statute [Section 25.5-4-402.3(4)(b), C.R.S.] states that subject to available revenue from the provider fee and federal matching funds, the hospital provider fee should be used to expand Medicaid-eligible populations. Based on the specific expansion of eligibility allowed by this statute, the Department plans to implement the following expansions of Medicaid and CHP+ services.

- Increase income eligibility limits from 60 percent to 100 percent of the federal poverty level for parents of children enrolled in Medicaid.

- Increase income eligibility limits from 205 percent to 250 percent of the federal poverty level for children and pregnant women under the CHP+ program.

- Establish a new program to provide health care coverage for adults who earn up to 100 percent of the federal poverty level and who do not have dependent children.

- Develop a new Medicaid buy-in program for disabled adults and children whose families earn up to 450 percent of the federal poverty level.

- Implement continuous eligibility for Medicaid-enrolled children for 12 months.

Revenue and Expenditures

Revenue for the Program comes from two primary sources: fees assessed on and paid by hospitals in accordance with the Provider Fee Model and federal matching funds. The Department also receives interest earned on the fees paid by hospitals through the Program. In addition, in Fiscal Years 2010 and 2011, the State received additional federal matching funds as part of an enhanced Federal Medical Assistance Percentage from the federal American Recovery and Reinvestment Act (Recovery Act).

The Recovery Act funds were part of the federal stimulus package funding awarded to states during Fiscal Years 2009 through 2012 to help states recover from the downturn in the economy. In State Fiscal Years 2010 and 2011, as a result of the Recovery Act funds, the Federal Medical Assistance Percentage for Colorado increased from 50 percent to a range of 57 to 62 percent on the supplemental payments to hospitals. However, Senate Bill 10-169 added Section 25.5-4-402.3(4)(b)(VIII), C.R.S., to the provider fee law, which required the federal matching funds for the supplemental payments to hospitals that were in excess of the 50 percent Federal Medical Assistance Percentage to be used to provide general fund relief in those two years. Consequently, in Fiscal Years 2010 and 2011, the Program received approximately $99.8 million in federal matching funds through the Recovery Act that were used for general fund relief.

As shown in the table on Page 10, in Fiscal Year 2012, the total revenue for the Program was more than $1.1 billion, which includes $585.7 million in provider fees, $528.3 million in federal matching funds, and almost $1 million in interest earned. The Program was designed to ramp up over the first several years. Consequently, the total revenue generated from the Program increased by 62 percent since its inception in Fiscal Year 2010.

Expenditures for the Program include supplemental payments made to hospitals, payments for services for individuals eligible under the expansion of Medicaid and CHP+ programs, administration, and four specific instances where hospital provider fees collected are used to offset general fund expenses. The specific amendments in Section 25.5-4-402.3(4)(b), subparts (VII), (VIII), and (IX), C.R.S., instructed the Department to collect hospital provider fees to (1) replace general fund revenue to offset the loss of federal matching funds to the State for the outpatient supplemental payment that Colorado was no longer eligible to receive after implementing the Hospital Provider Fee Program; this amounted to $7.9 million in Fiscal Year 2011 and $15.7 million in Fiscal Year 2012 being transferred from the Hospital Provider Fee Cash Fund (Cash Fund) to the general fund; (2) offset general fund expenditures in the Medicaid program with the federal matching funds received through the Recovery Act by the Hospital Provider Fee Program, in excess of the typical 50 percent matching rate;

this amounted to $46.3 million in general fund relief in Fiscal Year 2010 and $53.5 million in general fund relief in Fiscal Year 2011; (3) offset $50 million in state general fund expenses in Fiscal Year 2012; and (4) offset $25 million in state general fund expenses in Fiscal Year 2013.

As shown in the table below, in Fiscal Year 2012, $896.7 million was provided in supplemental payments to hospitals, $134.3 million was spent for expansion of Medicaid and CHP+ eligibility, $15.8 million was spent on the administration of the Program, and $65.7 million was used to offset general fund expenditures for the State share of Medicaid. Again, because the Program was designed to ramp up over the first few years, as expected, the expenditures for the Program have increased significantly since the first year.

Medicaid Hospital Provider Fee Program
Revenue and Expenditures by Source and State Fiscal Year
(In Millions)

Revenue and Expenditure Category	2010	2011	2012	Percentage Change 2010-2012
Revenue				
Hospital Provider Fees Collected	$340.9	$441.1	$585.7	72%
Federal Financial Participation[1]	298.4	422.9	528.3	77
Recovery Act Funding[2]	46.3	53.5	0.0	-100
Interest Earned	0.9	1.5	0.8	-11
Total Revenue	**$686.5**	**$919.0**	**$1,114.8**	**62%**
Expenditures				
Supplemental Payments	$590.2	$745.2	$896.7	52%
Expansion of Medicaid Eligibility	3.2	90.1	134.3	4,097
Administration	2.9	5.7	15.8	445
Medicaid General Fund Offset—Recovery Act[3]	46.3	53.5	0	-100
Medicaid General Fund Offset—Other[4]	0	7.9	65.7	100
Total Expenditures	**$642.6**	**$902.4**	**$1,112.5**	**73%**
Revenue Less Expenditures	**$43.9**	**$16.6**	**$2.3**	**-95%**
Refund to Hospitals	**$38.0**	**$0.0**	**$0.0**	**-100%**
Carry Over from Prior Fiscal Year	**$0.0**	**$5.9**	**$22.5**	**NA**
Cash Fund Balance	**$5.9**	**$22.5**	**$24.8**	**320%**

Source: Office of the State Auditor's analysis of hospital provider fee revenue and expenditures contained in the Colorado Financial Reporting System.

[1]Federal Financial Participation is the federal matching funds received based on the supplemental payments made to hospitals as part of the Hospital Provider Fee Program.

[2]American Recovery and Reinvestment Act provided an enhanced federal matching funds rate for supplemental payments in Fiscal Years 2010 and 2011, resulting in the State receiving a range of 57 to 62 percent reimbursement rather than 50 percent for supplemental payments made to hospitals as part of the Hospital Provider Fee Program.

[3]Medicaid General Fund Offset—Recovery Act includes federal matching funds received through the Recovery Act in excess of the 50 percent matching rate that were used for general fund relief per Section 25.5-4-4023(4)(b)(VIII), C.R.S.

[4]Medicaid General Fund Offset—Other includes transfers made to the general fund per Section 25.5-4-402.3(4)(b) subparts (VII) and (IX), C.R.S.

The amount of fees paid and supplemental payments received varies greatly by hospital. The Act specifies that some hospitals may be exempt from the hospital provider fee and some hospitals pay a reduced fee. Currently, freestanding psychiatric, long-term care, and rehabilitation hospitals are exempt from the fee, and small, rural hospitals and hospitals with very high volumes of Medicaid and CICP patient days are charged a reduced fee. For the most recently completed

model year (Model Year 2), 76 (78 percent) of the 97 licensed or certified hospitals in the State paid a hospital provider fee, and 21 hospitals were exempt from the provider fee under the regulations. Some hospitals that are exempt from the hospital provider fee still receive supplemental payments. In Model Year 2, there were 13 supplemental payments available to hospitals and, in total, 83 of the 97 hospitals received supplemental payments. Not every hospital is eligible for every payment. Most hospitals received more than one of the 13 supplemental payments available, and no hospital received all 13 of the supplemental payments. (See Appendix A for a complete list of the fee and payment amounts for hospitals in the State from the most recent Provider Fee Model.) Further, in comparing the amount of provider fees paid per hospital to the amount of supplemental payments received by that hospital, some hospitals experienced a net gain while other hospitals had a net loss. Just as hospital sizes vary, the losses and gains for hospitals varied greatly, with net losses ranging from $20,000 to $4.5 million and net gains ranging from $141 to about $88.8 million. In total, 13 hospitals experienced a net loss in Model Year 2, but six of those were part of a hospital system that overall had a net gain.

Audit Scope and Methodology

This performance audit was statutorily required pursuant to Section 2-3-119, C.R.S. Audit work was performed from December 2011 through September 2012. We acknowledge the cooperation and assistance provided by the Department staff, the Advisory Board, and the Medical Services Board as well as various hospital representatives throughout the State during this audit.

The objective of our audit was to determine compliance with federal and state laws and regulations in the implementation of the Act (House Bill 09-1293) and to assess the reliability of the data used in determining the hospital provider fees collected from and supplemental payments made to hospitals. Specifically, we reviewed:

- The Department’s compliance with federal and state laws for calculating the provider fees and supplemental payments, collecting fees, and distributing payments.
- The Department’s administrative expenditures related to the Program.
- The internal controls used by the Department to ensure the reliability and accuracy of the data used in the Hospital Provider Fee Model.

- The information system security measures in place to ensure the spreadsheet used to calculate the Provider Fee Model is reliable and secure.

To conduct this audit, the audit team:

- Researched applicable federal and state laws and regulations.
- Selected and reviewed a random sample of 30 discrete administrative expenditures from the Department's administrative purchases for the Program between July 2009 and March 2012.
- Interviewed Advisory Board and Medical Services Board members.
- Interviewed Department staff and reviewed Department documentation and data systems to determine Department processes and procedures for the implementation of the Act.
- Interviewed hospital representatives and reviewed hospital source documentation related to Model Years 1 through 4 of the Provider Fee Program for a judgmental, non-statistically valid sample of 10 hospitals to compare hospitals' data collection and reporting methods for the annual Hospital Provider Surveys.

To include a cross-representation of hospital types in our sample, we judgmentally selected a sample of 10 hospitals that provided representation of the following characteristics: large or small, rural or urban, private or public, critical access hospitals, hospitals that are part of a hospital system, and a hospital with a net loss from the Program.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Summary of Findings

Overall, the Department of Health Care Policy and Financing's (the Department) administration of the Program is in compliance with applicable federal and state laws. As part of the audit, we identified several improvements the Department

could make to better achieve the goals of the Program. Specifically, we found that:

- The Department relies, in part, on self-reported hospital data to determine the hospital provider fees hospitals must pay and the supplemental payments hospitals receive each year. During our audit, we found areas in which the Department can improve its data collection for the Program to better ensure the reliability of the data used in the Hospital Provider Fee Model and therefore improve the accuracy of the resulting fees and supplemental payments.

- The Department and the Advisory Board should work together to ensure that the hospital provider fees collected each year do not significantly exceed the amount needed to support the expenditures of the Program for that year. In particular, the Department should provide the Advisory Board updates on a quarterly basis of the status of the expansion populations' expenditures.

- The Department can improve the information system security controls related to the spreadsheet software used to construct the Provider Fee Model. Restricting user access to eliminate users who do not have a business need to access the file and implementing methods to track all changes made to the spreadsheet will improve the security of the file and better protect the Program calculations.

We discuss these issues and our recommendations in the remainder of this report.

Reliability of Provider Fee Model Data

In State Fiscal Year 2012, the Department paid more than $897 million in supplemental payments to hospitals in Colorado. Because the Provider Fee Model is the basis for determining how this large amount of state and federal resources is distributed, the calculations in the Provider Fee Model should be based on the most reliable hospital data possible. The Department uses a variety of data sources and data collection methods to calculate the provider fees assessed on and the supplemental payments made to hospitals. Some of these data sources are audited, and others are self-reported. The following table describes the data sources the Department used in Model Year 2 and how each of these data sources was used to calculate the two provider fees and 13 supplemental payments.

Medicaid Hospital Provider Fees Program Data Sources Used for Model Year 2 Hospital Provider Fees and Supplemental Payments		
Type of Fee/Payment	**Data Source Used for Calculation**	**Description of Data Source**
Hospital Provider Fees		
Inpatient Hospital Fee	Hospital Provider Survey*	The **Hospital Provider Survey** contains self-reported hospital data on 24 different data points used in the Provider Fee Model. The Department sends the Hospital Provider Survey to hospitals in March of each year and hospitals must complete and return the survey by April 30.
Outpatient Hospital Fee	Healthcare Cost Report Information System (HCRIS)	The **Healthcare Cost Report Information System (HCRIS)** is a CMS database used to track audited Medicare Cost Report data submitted by hospitals.
Supplemental Payments		
Outpatient Hospital Supplemental Medicaid Payment	Upper Payment Limit Financial Model & MMIS	**Upper Payment Limit Financial Model—**calculates the maximum amount, or Upper Payment Limit, that hospitals can receive in a given year in Medicaid reimbursement. CMS must approve the Department's methodology for the Upper Payment Limit Model. It is an estimate of how much hospitals would receive for providing Medicaid services if Medicare payment principles were used. **MMIS**—Colorado's Medicaid claims processing and information retrieval system.
Outpatient High-Volume Small Rural Hospital Supplemental Medicaid Payment	Upper Payment Limit Financial Model & MMIS	See description above.
Colorado Indigent Care Program (CICP) Disproportionate Share Hospital (DSH) Payment	CICP Annual Report	The **CICP Annual Report**, prepared by the Department and submitted each February 1 to the Senate Health and Human Services Committee and the House Health and Environment Committee of the General Assembly, lists the cost and payments for indigent care for hospitals and other health care providers annually.
CICP Supplemental Medicaid Payment	CICP Annual Report and Cost-to-Charge Ratio	**CICP Annual Report**—See description above. **Cost-to-Charge Ratio**—The Department contracts with Parrish, Moody and Fikes to provide the Cost-to-Charge Ratio that determines the Colorado Indigent Care Program and Uninsured Disproportionate Share payments to hospitals.
Uninsured DSH Payment	Hospital Provider Survey & Cost-to-Charge Ratio	See descriptions above.

Medicaid Hospital Provider Fees Program
Data Sources Used for Model Year 2
Hospital Provider Fees and Supplemental Payments

Type of Fee/Payment	Data Source Used for Calculation	Description of Data Source
Inpatient Hospital Base Rate Supplemental Medicaid Payment	Department Hospital Rate Section Financial Model	The **Hospital Rate Section Financial Model** is set by the Department's Rate Section. It determines the rates the State pays for various safety net services, such as the inpatient Medicare rate per discharge.
High-Level NICU Supplemental Medicaid Payment	NICU Days Worksheet	The **Neonatal Intensive Care Unit (NICU) Days Worksheet** is prepared by the Department and identifies the number of NICU days at hospitals in the State.
State Teaching Hospital Supplemental Medicaid Payment	Hospital Provider Survey	See description above.
Large Rural Hospital Supplemental Medicaid Payment	Hospital Provider Survey	See description above.
Denver Metro Supplemental Medicaid Payment	Hospital Provider Survey	See description above.
Metropolitan Statistical Area Supplemental Medicaid Payment	Hospital Provider Survey	See description above.
Pediatric Specialty Hospital Provider Fee Payment	No data required. All Pediatric Specialty Hospitals receive one flat-rate payment	NA
Acute Psychiatric Supplemental Medicaid Payment	Hospital Provider Survey	See description above.

Source: Office of the State Auditor analysis of Department of Health Care Policy and Financing information on data sources used to calculate the hospital provider fees and payments.

* The Hospital Provider Survey is a key source of data for the inpatient fee and six of the supplemental payments.

Because the Hospital Provider Survey is based on self-reported hospital data, we identified it as a high-risk data source for the Provider Fee Model. The other data sources for the model were primarily from systems or reports that had been audited and therefore would be lower risk. As a result, we compared a sample of 10 hospitals' data collection and reporting methods for the annual Hospital Provider Surveys for Model Years 1 through 4. We found that the data are not always accurate, consistent, or reliable. Specifically, we found:

Hospital Provider Survey data are not always accurate. We found inaccurate data reported by a hospital which led to that hospital receiving a payment it was

not entitled to under the Provider Fee Model. The Department guidelines for Model Year 3 required hospitals to report the number of Medicaid patient days associated with the hospital's "Distinct Psychiatric Unit." One of the 10 hospitals in our sample reported 2,141 Distinct Psychiatric Unit Medicaid patient days when in fact the hospital did not have a distinct psychiatric unit. The hospital did not follow the Department's instructions on the Hospital Provider Survey, and the error went undetected by the Department. As a result, in Model Year 3, the hospital received $428,200 in supplemental payments that it did not qualify to receive through the Acute Care Psychiatric treatment supplemental payment.

Hospital Provider Survey data are not always consistent. One hospital in our sample could not report its nonmanaged care patient days on its Hospital Provider Survey because its database is not designed to distinguish nonmanaged care and managed care patient days. The Department instructed the hospital to report its nonmanaged care patient days in the managed care category. However, the fee that hospitals pay per managed care day is much less than the fee paid per nonmanaged care day. Consequently, the hospital in our sample that reported nonmanaged care patient days as managed care patient days was charged a reduced overall fee. We were unable to determine the amount of the reduction in provider fees because the hospital was unable to separate the data. According to the Department there are other hospitals with similar difficulties separating their managed and nonmanaged care patient days on the Hospital Provider Survey. This type of inconsistent reporting of data results in inequitable fees among participating hospitals.

In addition, there were large variances in individual hospitals' data from year to year, indicating inconsistencies in the Hospital Provider Survey data. We compared the Hospital Provider Survey data for Model Years 1 through 4 for the 10 hospitals in our sample and found 86 of the 240 data points, about one-third, varied from one year to the next by more than 20 percent. According to Department staff, variances of more than 20 percent from the prior year's data could be an indication of an error or other problem with the data.

Hospital Provider Survey data are not always taken from the most reliable source. The Department allows hospitals to use self-reported data when data are already available from the hospital's existing and audited Medicare cost reports. For the data reported in their Hospital Provider Surveys, some hospitals use data directly from their Medicare cost reports, whereas others use data generated directly from their patient data systems or take system data and incorporate projections. As a result, data reported by some hospitals are not coming from the most reliable source. We performed additional analysis to determine whether there were significant differences between the self-reported data in the Hospital Provider Survey and the data in the hospitals' audited Medicare cost reports. We found:

- **Significant variances between self-reported data in the Hospital Provider Surveys and audited Medicare cost report data for multiple data points.** For the 10 hospitals in our sample, we compared the 53 data points that were available on the Medicare cost reports with the self-reported data provided by hospitals for the Model Year 3 Hospital Provider Survey. We found the data reported in the Hospital Provider Survey for 24 (45 percent) of the 53 data points varied by more than 10 percent from data reported in the audited Medicare cost report. This means that while some hospitals reported data in their surveys directly from the Medicare cost reports, other hospitals used different methods to determine their data that resulted in significant variation from the Medicare cost report data.

- **Significant variances between self-reported data and audited Medicare cost report data for total patient days.** According to the Department, there should not be more than a 5 percent variance between the total number of patient days reported on a hospital's Medicare cost report and the total number of patient days reported in the Hospital Provider Survey for the same year. This is because the total number of patient days represents the number of patients actually served by the hospital, and the total number of patient days should not change significantly in the time between when a hospital completes the Medicare cost report and when it completes the Hospital Provider Survey. We compared the total patient days reported from the Hospital Provider Survey for Model Year 3 to the Medicare cost reports that cover the same year for the 76 hospitals that pay a provider fee and found that 38 hospitals (50 percent) had a deviation of 5 percent or greater. Specifically, we found variances of between 5 and 49 percent for 30 hospitals and variances of 50 percent or more for eight hospitals.

Such significant variances between the data points in the Medicare cost reports and Hospital Provider Surveys raise concerns about the reliability of the data in the self-reported Hospital Provider Surveys.

Some hospitals could not provide documentation to support data reported in their Hospital Provider Surveys. We requested and reviewed the supporting documentation for the Hospital Provider Survey data reported by the 10 hospitals in our sample for Model Years 1 through 3. Of our sample of 10 hospitals, one hospital was not able to provide supporting documentation for any of the data reported in its surveys for any of the three model years. Additionally, three (30 percent) of the 10 hospitals in our sample could not provide supporting documentation for one or more of the 221 data points for one or more years.

We identified three areas in which the Department does not have adequate data collection procedures to ensure the accuracy, consistency, and reliability of the Hospital Provider Survey data that are used in the Provider Fee Model.

First, the Department does not use audited data that is already available. For the Inpatient Hospital Fee and six of the 13 supplemental payments in the Model, data are available in the audited Medicare cost reports. Using self-reported data creates an increased opportunity for unreliable and inaccurate data to be used in the Provider Fee Model and results in an increased need for oversight and review by the Department to ensure the data are reliable and consistent. Further, the hospitals have already compiled the data for the Medicare cost reports and could save time and effort by using the existing cost report data rather than compiling data again for the Hospital Provider Survey. Similar problems were identified in a 2011 federally required audit initiated by the Department that reviewed the Disproportionate Share Hospital (DSH) Program. In this report, Clifton Gunderson, a certified accounting firm, recommended that the Department establish a process to collect and retain the necessary documentation from hospitals to support the data reported and that the Department use existing, audited data to calculate the DSH payments. The Department reports that it is working to address the data collection concerns raised in the Clifton Gunderson audit by developing a uniform report system and comprehensive instructions and training for Colorado hospitals to gather the data elements the Department does not possess.

Second, the Department's instructions for the Hospital Provider Survey are not clear enough. Although the Department has made improvements each year in the quality of its Hospital Provider Survey instructions, eight of the 10 hospitals in our sample are still confused about how to determine one or more of the data points requested in the survey.

Third, the Department does not have sufficient controls over data used in the Provider Fee Model. The Department's reliance on self-reported data from the Hospital Provider Survey in the Provider Fee Model increases the need for the Department to implement oversight mechanisms to ensure that the self-reported data are accurate, consistent, and reliable. We reviewed the Department's processes for monitoring the accuracy of the data reported in the Hospital Provider Survey and found that the Department does not require hospitals to maintain supporting documentation for the data reported in the Hospital Provider Survey, and the Department does not conduct a risk-based review of supporting documentation for the data reported in the Hospital Provider Survey. Further, the Department does not have a robust process to follow up on large variances in data reported by hospitals from their prior-year data. For example, in Model Year 3, the Department conducted a comparison of the data points reported in the Hospital Provider Surveys to those reported the prior year for each hospital and made note of the data points that varied by more than 20 percent from those

reported the prior year. The Department staff briefly reviewed the variances and contacted some hospitals to request clarification. However, the Department does not have documentation of any follow-up action taken. The Department should continue conducting variance analysis and implement processes to ensure that it follows up and takes action on any variances, including, but not limited to, making adjustments to future fees and payments for errors.

Our review of hospital provider survey data for a sample of 10 hospitals showed that some hospitals are not reporting data accurately, consistently, or reliably, and the Department lacks an effective system of controls to monitor the data provided. As a result, the fees charged to hospitals and the supplemental payments made to hospitals may be incorrect or inequitable. Further, the Department's lack of procedures for reviewing data in the Hospital Provider Surveys creates a risk of abuse that hospitals could intentionally or unintentionally report false information and it would not be detected by the Department.

Recommendation No. 1:

The Department of Health Care Policy and Financing (the Department) should ensure the Hospital Provider Fee Model is based on accurate, consistent, and reliable data by:

a. Establishing data collection methods to obtain hospital data for the Hospital Provider Fee Model that are based on existing, reliable data sources where possible. The Department should consider gathering data directly, whenever possible, from the most recently available Medicare cost reports rather than requiring hospitals to self-report data in the Hospital Provider Survey.

b. Developing clear, consistent requirements for the data sources and methodologies hospitals must use to complete the Hospital Provider Survey.

c. Requiring hospitals to maintain supporting documentation for the data points reported in the Hospital Provider Survey.

d. Developing and implementing policies and procedures for an annual, risk-based review, to determine the accuracy and reliability of the self-reported data in the Hospital Provider Survey. The Department should also establish and implement procedures to take follow-up action with hospitals on data points in question, including, but not limited to, adjustments to future fees and payments for errors.

Department of Health Care Policy and Financing Response:

a. Agree. Implementation date: December 2013.

The Department recently contracted with a vendor to develop an online Uniform Inpatient and Outpatient Medicaid and Uninsured Care Cost and Charge Report (Uniform Cost Report) to allow hospitals to report data necessary for calculation of the hospital provider fee model and supporting documentation. The vendor began work on the Uniform Cost Report on July 1, 2012 and the first Uniform Cost Reports are scheduled to be received from hospitals in spring 2013 for use in the 2013-14 hospital provider fee model.

b. Agree. Implementation date: December 2013.

As part of the development of the Uniform Cost Report described in Part a., a comprehensive manual and instructions for hospitals will be developed that will identify acceptable and preferred data sources and describe appropriate and accurate data collection and retention methods.

c. Agree. Implementation date: December 2013.

The manual referred to in Part b. will describe requirements for maintenance of supporting records. In addition, the vendor will conduct annual training for hospitals throughout the state.

d. Agree. Implementation date: December 2013.

The Department will develop policies and procedures to review submitted information for all hospitals for accuracy and to determine when an adjustment to assessed fees or payments will be made. In addition, the vendor will conduct annual desk reviews of submitted Uniform Cost Reports and supporting documentation for selection of hospitals each year.

Collecting Excess Hospital Provider Fees

Statute [Section 25.5-4-402.3(3)(b)(II), C.R.S.] requires the amount collected from the hospital provider fee and federal matching funds generated from the hospital provider fee be sufficient to pay for the purposes outlined in statute.

Annually, using the Provider Fee Model, the Department calculates the total amount of hospital provider fees needed to meet the anticipated costs for the Program's purposes. The original uses for the provider fee outlined in statute are to (1) increase reimbursements to hospitals for providing medical care under the State medical assistance program and CICP, (2) expand eligibility for public medical assistance to the expansion populations identified in statute, and (3) cover Department administrative costs related to the Program. In accordance with Senate Bill 11-212, the hospital provider fee is also allowed to be used to offset a portion of the general fund's share of Medicaid expenditures in Fiscal Years 2012 and 2013. In addition, to comply with statute, the Provider Fee Model includes the specific costs for which the provider fee will be used each year.

As a result, it is imperative that the Department and the Advisory Board review the calculations and underlying projections for the Provider Fee Model throughout the course of the year and make adjustments, as necessary, to ensure that it does not collect more hospital provider fees than are needed to support the statutory purposes of the Program in a given year.

The Department, with the approval of the Advisory Board and Medical Services Board, may retain unused provider fees collected each year. We reviewed the revenues and expenditures for the Program and determined that the Department collected significantly more in hospital provider fees than it needed to fund the Program during each of the first three years. At the end of each State Fiscal Year, the Department made recommendations to the Advisory Board on whether the Department should issue a refund of unused hospital provider fees to the hospitals that year and/or carry over excess funds to the next year. The Department and the Advisory Board then submit a final recommendation to the Medical Services Board for approval. In each of the first three years of the Program, the Department and Advisory Board recommended to the Medical Services Board to carry over excess provider fees to the next year. The table below shows the amount of funds remaining in the Cash Fund at the end of each fiscal year and the amount refunded to hospitals in each year.

Medicaid Hospital Provider Fee Program
Hospital Provider Fee Cash Fund Balance by State Fiscal Year
(In Millions)

Fiscal Year	Cash Fund Balance	Amount Refunded to Hospitals	Cash Fund Balance Carried Over
2010	$43.9	$38.0	$5.9
2011	$22.5	$0.0	$22.5
2012	$24.8	$0.0	$24.8

Source: Office of the State Auditor's analysis of Colorado Financial Reporting System data.

The Cash Fund balance at the end of State Fiscal Year 2010 was approximately $43.9 million. The Department refunded hospitals $38 million and carried over $5.9 million in unused hospital provider fees and interest earned. At the end of State Fiscal Year 2011, approximately $22.5 million remained in the Cash Fund and those funds were all rolled into the next model year to fund a portion of the Senate Bill 11-212 requirement for the Department to collect $50 million in provider fees in Fiscal Year 2012 to offset the State general fund's share of the Medicaid matching funds. Finally, $24.8 million remained in the Cash Fund at the end of State Fiscal Year 2012 and at its July 2012 meeting, the Advisory Board approved a recommendation to the Medical Services Board to carry over the full amount to pay for anticipated expansion population costs for Model Year 4 and currently the Department is waiting on the Medical Services Board approval to carry over those funds.

During our audit, we found that the majority of the overcollections in the first two years of the Program are attributable to the fact that the Department overestimated the amount of provider fees needed to fund the expansion populations. Based on the Department's estimates of expansion population costs, and the resulting fees collected, the table below shows that in Model Year 1, the Department collected $25.6 million more in fees to pay for expansion services than it spent on the expansion population. In Model Year 2, the Department collected $13 million more than it spent on the expansion population costs for that year. Model Year 3 will not be completed until September 30, 2012 and the Department's estimates for the expansion population costs are made for the entire model year, rather than by month or quarter. Further, the Department reports that expansion population cost estimates cannot be prorated for only a portion of the year since the cost estimates in the Hospital Provider Fee Model are based on the assumption that expenditures are not incurred equally throughout the model year. As a result, at the time of our audit, the Department was unable to project the amount of the expansion population cost estimate for Model Year 3 that could be compared to the actual expenditures as of June 30, 2012. However, for Model Year 3, the Department estimated expansion costs of $105.4 million and as of June 30, 2012, which is three quarters of the model year, it had expended approximately $50.3 million for the expansion populations. While expenditures for expansion populations are expected to increase in the fourth quarter of Model Year 3 due to the recent implementation of two expansion populations, we are concerned that the Department will likewise overcollect fees in Model Year 3 as it had previously. The table below compares the estimated expansion population costs contained in the Provider Fee Model to the actual expenditures by model year.

Medicaid Hospital Provider Fee Program
Comparison of Estimated to Actual Expansion Population Costs by Model Year
As of June 30, 2012
(In Millions)

Model Year	Expansion Population Costs Estimated in Model	Actual Expended	Amount Collected and Not Spent
Model Year 1	$27.2	$1.6	$25.6
Model Year 2	$60.9	$47.9	$13.0
Model Year 3	$105.4	$50.3[1]	To Be Determined[2]

Source: Office of the State Auditor's analysis of Hospital Provider Fee Model and Colorado Financial Reporting System data.

[1] Model Year 3 only includes actual expenditures as of June 30, 2012, which covers the first three quarters of the model year.

[2] For Model Year 3, actual expenditures are only known for the first three quarters of the model year and therefore the Department was unable to estimate the amount collected and not spent for Model Year 3.

The Department reports several reasons for the overcollection of provider fees for the expansion populations in the first three years of the Program.

- First, the Department's Budget Section uses statistical analysis to project the total cost for each expansion population it will serve during the model year; however, the Department stated that determining estimates for new expansion populations is difficult in the early years of a new program because there are a number of factors that cannot be easily estimated. As a result, estimates are likely to be off in the first year or two of a program.

- Second, the Department reported that an error in the way enrollment spans are communicated between the Department's eligibility and billing systems led to the overestimation of the CHP+ expansion populations in all model years.

- Third, the expansion population cost estimates for Model Year 2 included $5.2 million for the Disabled Buy-in program that was not implemented until Model Year 3.

- Finally, in Model Year 3, the Department anticipates only using approximately $15 million of the $40 million in the Model for the Adults without Dependent Children expansion population that year.

While the Department reports not wanting to overcollect hospital provider fees, each year since the Program began the hospitals have paid fees in excess of what was needed to pay for the expenditures. In addition, the Cash Fund is earning interest on the hospital provider fees that could otherwise be used by hospitals. According to Section 25.5-4-402.3(4)(c), C.R.S., interest earned from hospital

provider fees shall remain in the Cash Fund, cannot be used for purposes other than those specified in the statute, and must be used for the Program in future fiscal years. For instance, the Department collected approximately $43 million more than it needed to pay for Program costs during Model Year 1, yielding the Cash Fund approximately $900,000 in interest during the three months the Program was in operation that year. The $900,000 in interest earnings remained in the Cash Fund to be used in the next fiscal year.

According to Section 25.5-4-402.3(6)(e)(I), C.R.S., the Advisory Board is responsible for recommending to the Department the timing, method of assessment and amount of the provider fee. Thus, the Department must seek Advisory Board approval of the Provider Fee Model that includes the expansion population cost estimates and any mid-year changes to the Provider Fee Model. However, our interviews with Department staff and review of Advisory Board meeting minutes indicate the Department does not provide the Advisory Board with updates throughout the year on the actual expansion population expenditures as compared to the expansion population costs estimated in the Provider Fee Model for that year. Therefore, the Advisory Board has not had the updated information necessary to make decisions about the timing and amount of the hospital provider fee or to make mid-year adjustments, if needed. Ultimately, the Advisory Board is not ensuring that fees do not significantly exceed the Program's actual needs each year. The Department has not been providing the Advisory Board with quarterly updates on the expansion population expenditures that would provide the Advisory Board the opportunity to monitor and proactively advise the Department on the best use of excess hospital fees and the ability to make recommendations about mid-year adjustments to fees if they are warranted in order to reduce the financial burden on hospitals.

Recommendation No. 2:

The Department of Health Care Policy and Financing (the Department) and the Hospital Provider Fee Oversight and Advisory Board (Advisory Board) should improve the monitoring of the Hospital Provider Fee Program expansion population expenditures to ensure that the Department does not charge hospitals a hospital provider fee significantly greater than what is needed to cover the costs of the expansion population in the current model year. Specifically:

a. The Department should provide quarterly updates to the Advisory Board comparing Model estimates for the expansion populations to the actual program expenditures for the expansion populations.

b. The Advisory Board should review the expansion population expenditures quarterly and, if necessary, make recommendations to the Department and

the Medical Services Board about the need to revise the Hospital Provider Fee Model to ensure the amount collected for expansion populations more accurately reflects the expansion population costs, and if necessary consider mid-year adjustments to fees in the event it appears that the Department will significantly overcollect in a given year.

Department of Health Care Policy and Financing Response:

a. Agree. Implementation date: March 2013.

On a quarterly basis, the Department will report the actual versus estimated fees and expenditures for expansion populations to the Advisory Board for their review and recommendation.

Hospital Provider Fee Oversight and Advisory Board Response:

b. Agree. Implementation date: March 2013.

The Advisory Board will review the actual expenditures for Medicaid and CHP+ expansions funded by hospital provider fees on a quarterly basis. The Advisory Board will make recommendations to the Department and the Medical Services Board as it finds necessary to ensure that fees collected are sufficient, but not significantly greater than needed, to fund expenditures for expansion populations.

Information Technology Security

The Department utilizes a spreadsheet that includes a complex set of calculations to compile the Provider Fee Model each year. As described in previous sections of this report, data are taken from a variety of sources annually and entered by Department staff into the Provider Fee Model spreadsheet to determine the amount each hospital will pay in fees and receive in supplemental payments for that year. Because of the monetary size of the Program and the complicated nature of the Provider Fee Model, it is critical for the Department to ensure that the information contained in the Provider Fee Model spreadsheet is secure and can only be accessed and modified by appropriately authorized staff. Best practices in the area of information security recommend the following controls for information systems similar to the Hospital Provider Fee Model spreadsheet:

- **The State of Colorado Information Security Policy on Access Control (P-CISP-008)—**requires state agencies to "limit user access to the minimum required to perform assigned duties." Specifically, the policy requires access to networks, applications, files, and records be restricted to only those users that have a business need to read, write, or modify the data.

- **NIST Special Publication 800-53*, Recommended Security Controls for Federal Information Systems and Organizations*—**requires that financially significant systems, such as the spreadsheet used by the Department for the Provider Fee Model, have in place mechanisms to log changes made to applications that distribute funds in order for administrators to track changes made to them in the event those changes have to be reviewed or reversed.

During our audit, we reviewed the Department's security measures for the Provider Fee Model spreadsheet. Overall, we identified two areas for improvement.

- **Restricting User Access—**The Department has not sufficiently restricted access to the network folder that contains the Provider Fee Model spreadsheet. During our review, we found 16 Department staff members (14 in the Safety Net Program and two Department-level support staff) have access to the Provider Fee Model spreadsheet that would enable them to read, write, and modify the documents. However, according to the Department, only four Department staff members have a business need to access the Provider Fee Model spreadsheet. As a result, there are 12 Department staff with no business need to access the Provider Fee Model spreadsheet that can access the spreadsheet. Department staff members with excessive privileges and access to the Provider Fee Model could potentially make unauthorized changes to it.

- **Developing a Method to Track Changes—**The Department does not currently have a method for tracking changes in the spreadsheet used for the Provider Fee Model. As a result, changes made within the spreadsheet, such as data changes within a cell, changes to formulas, and deleted data, are not being tracked. Tracking changes to the Provider Fee Model spreadsheet is important because the Department staff create several iterations of the Provider Fee Model during the process of finalizing it each year. Since the Department is unable to effectively track changes, the Department does not have a history of the changes made, thus, the Department does not have the capacity to hold employees accountable for the maintenance and correct calculations in the Provider Fee Model. Also,

the Department does not have a log of changes made in cases in which changes need to be reversed.

The Department does not have adequate controls to restrict unnecessary user access to the Provider Fee Model spreadsheet to ensure that the calculations and data in the Provider Fee Model are sufficiently controlled. In addition, the Department does not have a mechanism in place to automatically track and log all changes to the information and formulas contained in the spreadsheet.

Recommendation No. 3:

The Department of Health Care Policy and Financing (the Department) should improve the information security of the Provider Fee Model spreadsheet by:

a. Restricting access to the Provider Fee Model spreadsheet to only those users who have a business need to access it.

b. Developing a method to track changes in the Provider Fee Model spreadsheet that allows the Department to document the history of changes made in the spreadsheet over time.

Department of Health Care Policy and Financing Response:

a. Agree. Implementation date: November 2012.

The Department will restrict access to the current hospital provider fee model to only those users who have a business need to access it immediately.

b. Agree. Implementation date: October 2013.

The Department will identify and utilize a logging and/or versioning feature to track changes during model development beginning with the next model year.

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Appendix

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Appendix A

Medicaid Hospital Provider Fees Program Model Year 2[1] Fees Paid and Supplemental Payments Received by Hospital (In Millions)				
Hospital	**County**	**Fees Paid**	**Supplemental Payments Received**	**Net Gain/Loss to the Hospital**
State Hospitals[2]				
University of Colorado Hospital	Adams	($20.2)	$63.5	$43.3
Colorado Mental Health Institute-Fort Logan	Denver	0.0	0.0	0.0
Colorado Mental Health Institute-Pueblo	Pueblo	0.0	0.0	0.0
Government Hospitals[3]				
Pagosa Mountain Hospital	Archuleta	(0.1)	0.7	0.6
Southeast Colorado Hospital	Baca	(0.2)	0.5	0.3
Heart of the Rockies Regional Medical Center	Chaffee	(0.5)	1.5	1.0
Keefe Memorial Hospital	Cheyenne	(0.1)	0.1	(0.0)
Delta County Memorial Hospital	Delta	(3.4)	4.8	1.4
Denver Health Medical Center	Denver	(17.0)	105.9	88.9
Memorial Hospital	El Paso	(25.1)	50.3	25.2
Grand River Medical Center	Garfield	(0.4)	1.3	0.9
Kremmling Memorial Hospital	Grand	(0.3)	0.2	(0.1)
Gunnison Valley Hospital	Gunnison	(0.2)	0.5	0.3
Spanish Peaks Regional Health Center	Huerfano	(0.2)	1.2	1.0
Weisbrod Memorial County Hospital	Kiowa	0.0	0.2	0.2
Kit Carson County Memorial Hospital	Kit Carson	(0.2)	0.5	0.3
St. Vincent General Hospital District	Lake	(0.1)	0.4	0.3
Estes Park Medical Center	Larimer	(0.3)	1.4	1.1
Poudre Valley Hospital	Larimer	(18.4)	27.4	9.0
Lincoln Community Hospital and Nursing Home	Lincoln	(0.1)	0.5	0.4
The Memorial Hospital	Moffat	(0.4)	1.7	1.3
Southwest Memorial Hospital	Montezuma	(1.0)	2.0	1.0
Montrose Memorial Hospital	Montrose	(3.9)	6.7	2.8

Medicaid Hospital Provider Fees Program Model Year 2[1] Fees Paid and Supplemental Payments Received by Hospital (In Millions)				
Hospital	**County**	**Fees Paid**	**Supplemental Payments Received**	**Net Gain/Loss to the Hospital**
East Morgan County Hospital	Morgan	(0.2)	1.4	1.2
Arkansas Valley Regional Medical Center	Otero	(3.0)	6.0	3.0
Haxtun Hospital	Phillips	(0.1)	0.1	0.0
Melissa Memorial Hospital	Phillips	(0.2)	0.7	0.5
Aspen Valley Hospital	Pitkin	(0.6)	1.4	0.8
Prowers Medical Center	Prowers	(0.8)	3.0	2.2
Pioneers Hospital	Rio Blanco	(0.1)	0.2	0.1
Rangely District Hospital	Rio Blanco	(0.1)	0.1	0.0
Sedgwick County Memorial Hospital	Sedgwick	(0.1)	0.2	0.1
North Colorado Medical Center	Weld	(20.3)	34.1	13.8
Wray Community District Hospital	Yuma	(0.2)	0.4	0.2
Yuma District Hospital	Yuma	(0.3)	1.1	0.8
Private Hospitals[4]				
Centura Health - Saint Anthony North Hospital	Adams	(7.7)	12.3	4.6
Haven Behavioral Health at North Denver	Adams	0.0	0.0	0.0
HealthOne North Suburban Medical Center	Adams	(7.6)	10.4	2.8
HealthOne Spalding Rehabilitation Hospital	Adams	0.0	0.2	0.2
Platte Valley Medical Center	Adams	(3.8)	10.6	6.8
The Children's Hospital	Adams	(9.9)	30.5	20.6
Vibra Long Term Acute Care Hospital	Adams	0.0	0.1	0.1
San Luis Valley Regional Medical Center	Alamosa	(3.3)	8.4	5.1
Centura Health - Littleton Adventist Hospital	Arapahoe	(9.7)	6.6	(3.1)
Craig Hospital	Arapahoe	0.0	1.4	1.4
HealthOne Medical Center of Aurora	Arapahoe	(22.2)	21.1	(1.1)

Medicaid Hospital Provider Fees Program
Model Year 2[1] Fees Paid and Supplemental Payments Received by Hospital
(In Millions)

Hospital	County	Fees Paid	Supplemental Payments Received	Net Gain/Loss to the Hospital
HealthOne Swedish Medical Center	Arapahoe	(22.0)	20.2	(1.8)
Triumph Hospital	Arapahoe	0.0	0.0	0.0
Boulder Community Hospital	Boulder	(12.4)	12.4	0.0
Centennial Peaks Hospital	Boulder	0.0	0.0	0.0
Centura Health - Avista Adventist Hospital	Boulder	(5.1)	8.5	3.4
Exempla Good Samaritan Medical Center	Boulder	(6.3)	4.4	(1.9)
Longmont United Hospital	Boulder	(11.2)	17.3	6.1
Conejos County Hospital	Conejos	(0.2)	1.6	1.4
Centura Health - Porter Adventist Hospital	Denver	(13.6)	11.3	(2.3)
Colorado Acute Long Term Hospital	Denver	0.0	0.0	0.0
Eating Recovery Center	Denver	0.0	0.0	0.0
Exempla Saint Joseph Hospital	Denver	(15.2)	22.6	7.4
HealthOne Presbyterian/St. Luke's Medical Center	Denver	(18.2)	29.7	11.5
HealthOne Rose Medical Center	Denver	(15.8)	17.5	1.7
Kindred Hospital	Denver	0.0	0.1	0.1
National Jewish Health	Denver	(0.4)	5.7	5.3
Select Specialty Hospital - Denver	Denver	0.0	0.0	0.0
Select Specialty Hospital - Denver South Campus	Denver	0.0	0.0	0.0
Centura Health - Parker Adventist Hospital	Douglas	(4.8)	4.8	(0.0)
HealthOne Sky Ridge Medical Center	Douglas	(8.9)	4.4	(4.5)
Highlands Behavioral Health System	Douglas	0.0	0.0	0.0
Vail Valley Medical Center	Eagle	(2.8)	2.9	0.1
Cedar Springs Behavior Health System	El Paso	0.0	0.0	0.0
Centura Health - Penrose St. Francis Health Services	El Paso	(27.4)	23.6	(3.8)

Medicaid Hospital Provider Fees Program
Model Year 2[1] Fees Paid and Supplemental Payments Received by Hospital
(In Millions)

Hospital	County	Fees Paid	Supplemental Payments Received	Net Gain/Loss to the Hospital
HealthSouth Rehabilitation Hospital	El Paso	0.0	0.2	0.2
Peak View Behavioral Health	El Paso	0.0	0.0	0.0
Select Long Term Care Hospital	El Paso	0.0	0.0	0.0
Centura Health - St. Thomas More Hospital	Fremont	(3.4)	6.5	3.1
Valley View Hospital	Garfield	(4.2)	9.1	4.9
Centura Health - Ortho Colorado	Jefferson	(2.1)	0.0	(2.1)
Centura Health - Saint Anthony Central Hospital	Jefferson	(17.7)	23.1	5.4
Exempla Lutheran Medical Center	Jefferson	(22.2)	21.3	(0.9)
Animas Surgical Hospital	La Plata	(0.2)	0.5	0.3
Mercy Medical Center	La Plata	(4.8)	6.9	2.1
McKee Medical Center	Larimer	(6.0)	12.7	6.7
Medical Center of the Rockies	Larimer	(5.0)	7.9	2.9
Mount San Rafael Hospital	Las Animas	(0.8)	1.8	1.0
Sterling Regional Medical Center	Logan	(2.3)	4.4	2.1
Community Hospital	Mesa	(2.6)	2.4	(0.2)
Family Health West Hospital	Mesa	0.0	0.1	0.1
St. Mary's Hospital and Medical Center	Mesa	(18.9)	21.6	2.7
West Slope Mental Health Stabilization Center	Mesa	0.0	0.0	0.0
Colorado Plains Medical Center	Morgan	(1.8)	3.1	1.3
Centura Health - St. Mary-Corwin Medical Center	Pueblo	(11.6)	24.3	12.7
Haven Behavioral Senior Care at St. Mary-Corwin	Pueblo	0.0	0.0	0.0
Parkview Medical Center	Pueblo	(21.6)	35.4	13.8
Rio Grande Hospital	Rio Grande	(0.3)	0.9	0.6
Yampa Valley Medical Center	Routt	(1.7)	3.2	1.5
Centura Health - Saint Anthony Summit Hospital	Summit	(0.6)	1.7	1.1
Pikes Peak Regional Hospital	Teller	(0.1)	1.0	0.9

Medicaid Hospital Provider Fees Program
Model Year 2[1] Fees Paid and Supplemental Payments Received by Hospital
(In Millions)

Hospital	County	Fees Paid	Supplemental Payments Received	Net Gain/Loss to the Hospital
Northern Colorado Rehabilitation Hospital	Weld	0.0	0.2	0.2
Total		($474.5)	$796.9	$322.4

Source: Model Year 2 data provided by the Colorado Department of Health Care Policy and Financing.

[1]These fees and supplemental payments are for Hospital Provider Fee Model Year 2 (October 1, 2010–September 30, 2011). As a result, the fees and supplemental payments in this table do not correspond to the State Fiscal Year amounts in the report.

[2]State hospitals are operated directly by the State of Colorado.

[3]Government hospitals are operated by counties or municipal governments.

[4]Private hospitals are private nonprofit and for-profit hospitals.

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