Colorado Indigent Care Program Manual

Fiscal Year 2020-21

Section III: Provider Audit

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CICP

Colorado Indigent Care Program

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ARTICLE I. AUDIT OVERVIEW

Section 1.01 Provider Compliance Audit and Purpose

To meet its fiduciary responsibility, the Colorado Indigent Care Program (CICP) requires that participating providers submit to a provider compliance audit and submit a Corrective Action Plan (CAP), when required, to the Department of Health Care Policy and Financing (the Department). The purpose of the provider audit is to furnish the Department with a report that attests to provider compliance with specified provisions of the CICP provider agreement, regulations and manual. The following guidelines provide a basis for conducting the provider audit.

Section 1.02 Records and Audit Documentation Retention and Availability

All records, documents, reports, communications and other materials (except for medical records of CICP clients) related to the participating CICP Provider's and any subcontractor's participation in the CICP shall be the property of the State and maintained in a central location by the provider as custodian thereof on behalf of the State, and shall be accessible to the State for a period of six (6) State fiscal years after the expiration of each State fiscal year. A further retention period may be necessary to resolve any matter which is pending at the expiration of each six (6) state fiscal year period.

The provider will keep the material associated with conducting this audit, such as the audit work papers and corrective action plans, for a period of six (6) State fiscal years following the conclusion of the audit. This must demonstrate that the audit was performed within the standards outlined in this section. If an audit by or on behalf of the federal and/or State government has begun, but is not completed at the end of the six (6) State fiscal year period, or if audit findings have not been resolved after the six (6) State fiscal year period, such materials shall be retained for six (6) months after the filing of the final audit report and response thereto. This material will not be submitted to the Department unless a direct request for the documentation is made.

Section 1.03 CICP Administrative Audit

All providers are subject to an audit by the Department or a designee representing the Department. This audit will examine the provider's eligibility and billing records. The provider will be notified in writing by the Department's auditor prior to conducting this audit. At that time, the provider will be notified regarding the audit's scope and criteria.

Section 1.04 Provider Compliance Audit Reporting Period

The audit period covers the previous state fiscal year for the Eligibility section of the audit and the most recently submitted calendar year data for the Billing section of the audit. For example, the audits conducted in 2019-20 will cover the 2018-19 program year for the Eligibility section and calendar year 2018 for the Billing section.

Section 1.05 Provider Compliance Audit Sections

The following audit guidelines represent the audit requirements and the reporting process. There are two separate components of the CICP Compliance Audit.

1. **Eligibility Audit:** This audit examines only eligibility applications completed directly by the provider. Clients serviced by the provider under the CICP but screened by another facility should not be included.
2. **Billing Audit:** This audit examines the provider's billing records and the summary information submitted to the CICP.

Section 1.06 Non-Compliance

Providers that are found to be out of compliance with any of the CICP guidelines must implement a CAP. A statement from the provider's administration must be submitted to the Department describing the plan of correction and an implementation date. The Department will send a letter to the provider identifying the errors found in the audit that must be addressed in the CAP. The CAP will be due to the Department within ten (10) business days from the date of the letter. Failure to submit a CAP may result in withholding CICP payments until such a plan is received or the CICP may redirect payments to compliant providers.

Section 1.07 Penalty

Failure to comply with the Department's auditor for any year in which a provider participates in the CICP may result in the Department billing the provider for a full refund of monies received for the period in question or withholding payments until the audit has been completed to the Department's satisfaction. Failure to pay this refund will result in this issue being turned over to the State for collection. Further, the Department will not approve a provider to participate in the CICP until the refund is paid in full.

Section 1.08 Audit Disagreements

Any disagreement between the audit procedures, CICP Manual, and provider policies should be resolved between the auditor and provider. If the auditor and provider cannot reach resolution, jointly and concurrently, both parties should contact the Department for clarification.

ARTICLE II. METHODOLOGY AND PROCEDURES

Section 2.01 Timeframe

The table below lays out the audit timeline. Please see the following sections for specific details and work steps for each phase of the audit.

Audit Phase	Timeline and Description
Provider Notification	Provider will be notified in writing that they have been selected for audit
Entrance Conference	Entrance conferences are normally held within two weeks of audit notification
Data Collection	Providers are given sixty (60) days from the date of their entrance conference to collect and submit the required data
Conduct Audit	The audit will be conducted following the submission of all required data, usually lasting four to six weeks
Prepare Results Report	An audit report will be prepared and sent to the provider the day before the Exit Conference for the provider to review
Exit Conference	An Exit Conference will be scheduled after the audit is completed and an audit report is prepared
Review Period	The provider will have five (5) business days after the Exit Conference to review and submit any missing data to the auditor
Finalization of Audit	The auditor will review and finalize the audit report using any extra data submitted within the five (5) day Review Period and send a final report to the provider and the Department
Appeals	The provider will have five (5) business days from the date of the final audit report to appeal the findings, the process for which can be found in Section 2.09 Appeals Process

Section 2.02 Provider Notification

The auditor will distribute an Audit Notification Letter informing the provider of their selection for the Colorado Indigent Care Fund audit. This letter will supply the provider with anticipated timelines for conducting the audit and outline the general audit process around the Eligibility and Billing portions of the audit. The letter will also identify key contacts from both the Department and the auditor and include all relevant contact information including telephone numbers and e-mail addresses. Following the distribution of this letter, the auditor will request a meeting with facility contacts to conduct the Audit Entrance Conference.

Section 2.03 Audit Entrance Conference

After the Notification Letter is distributed, the auditor, the Department, and relevant facility personnel will conduct an Audit Entrance Conference to formally introduced the audit team, outline the scope of the audit, and review audit compliance requirements. The purpose of this meeting is to educate the facility on the audit objectives, review the comprehensive data request with the provider, discuss the audit schedule and address timelines and expectations from all parties. Staff from the provider will have the opportunity to ask any questions about the audit process during this meeting. The auditor's contact information will be shared with the facility so that the audit team can clarify any additional questions that may arise during the data collection process.

Section 2.04 Data Collection

Following the completion of the Entrance Conference, the data collection process will begin. Due to the sensitive nature of the data that will be collected, the auditor will establish a Secure File Transfer Protocol (SFTP) site to facilitate the transfer of Protected Health Information (PHI). The first pieces of data the auditor will request will be two separate lists of clients: one list of CICP applications that were completed during the previous state fiscal year and one list of unduplicated CICP patients that were included in the most recent data submission. These lists will be used to generate the sample of patients that will be examined as a part of both the Eligibility and Billing portions of the audit respectively. Data for patients identified in the sample will be due 60 days from the date of receipt of the Audit Notification Letter. The size of the audit sample is based on the number of patients reported in the most recent data submission as described below. Additionally, for providers with satellite facilities, an extra five applications per satellite facility will be added to the sample size.

Number of Clients Served	Audit Sample Size
<25	All
26-100	25
101-400	35
401-800	50
801-2500	60
2501+	70

The auditor will randomly select clients from each list and provide the list of chosen clients for each audit to the provider. The provider will then be responsible for providing all necessary documentation for each client to the auditor prior to the end of the Data Collection period. For clients selected for the Eligibility audit, all documents related to their rating should be submitted to the auditor. These files should be submitted as separate PDFs for each client. For clients selected for the Billing audit, documentation from all CICP visits within the calendar year should be submitted as well as the client's application or CICP card. The visit data should be submitted in an Excel file, and the applications and/or cards should be submitted in separate PDFs for each client. If the provider is unable to provide the file types as stipulated, they should contact the auditor to discuss alternative acceptable file types.

Providers will also be asked for the backup documentation to support the annual program data submitted to the Department, as well as the facility chargemaster. These files should be submitted as Excel files. If the provider is unable to provide Excel files, they should contact the auditor to discuss alternative acceptable file types. **Providers should keep the documentation used when compiling the visit data to be submitted to the Department and using that for the audit.** Pulling the data at the time of the audit most likely will result in discrepancies between the data submitted and the recently pulled data due to adjustments made after the data was submitted.

Section 2.05 Conduct Audit and Prepare Audit Report

After all necessary audit data is submitted, the auditor will begin conducting the audit. The audit objectives and processes for both the Eligibility and Billing portions of the audit are detailed in the following articles. The auditor will be in communication with the provider throughout the audit process to clarify questions they have with submitted data and answer questions the provider may have. Questions about the audit process should be directed to the auditor.

Section 2.06 Exit Conference

After the audit report has been prepared, the auditor will contact the provider to set up an Exit Conference with the relevant facility personnel. The provider will receive their draft audit report the day before the Exit Conference for review and will have the opportunity to ask any and all questions they have about the audit report at the Exit Conference.

Section 2.07 Review Period and Finalization of Audit

The provider will have five (5) business days from the date of the Exit Conference to submit any missing or clarifying data to the auditor. The auditor will review and finalize the audit report using any data submitted within the Review Period. The final audit report will then be sent to the provider and the Department. The draft audit report will become the final audit report if the provider does not submit any additional data within the Review Period. No additional data will be accepted after the Review Period.

Section 2.08 Implications of Final Audit Report

The eligibility audit focuses on the applications completed by the provider and checks them for adherence to the CICP rules as well as the provider's definition of income, family size, etc. Any errors identified in the eligibility audit will be presented to the provider by the state contracted auditor, and the provider will be responsible for addressing each error in a CAP. The CAP needs to include how the provider will address and correct the identified errors and a timeline in which those errors will be addressed.

The billing audit focuses on the billing records for the chosen audit sample. The billing records will be checked to ensure that clients were billed using the correct copayment, that the charged copayment matches the service that was provided, any third-party payments were reported accurately, and that the charges were the same as those billed to non-CICP clients. The CICP will use a 2% threshold to determine if a clinic provider's

funding will need to be adjusted based on the findings. If the findings result in less than a 2% difference between reported charges, copayments, and third-party liability, no adjustment will be made. Additionally, any findings that exceed 2% will be adjusted by 2% (i.e. a 5% total finding will be reduced to a 3% finding). Any findings in the billing audit will also need to be addressed in the provider's submitted CAP.

Hospital providers will not be subject to an adjustment to their funding based on the state's contracted auditor findings due to the fact that they are already audited on their financials annually during the Disproportionate Share Hospital (DSH) audits. Hospital providers will still be responsible for addressing any billing findings in their submitted CAP.

Section 2.09 Appeals Process

If a provider disagrees and would like to appeal the audit findings, the provider may file a dispute in writing to the State Programs Unit Lead at hcpf_CICPCorrespondence@state.co.us within five (5) business days after the provider's Exit Conference with the state's auditor. Following receipt of the dispute, the State Programs Unit Lead will perform a review of the validation process to determine if the basis of the dispute is valid. No new data, information, or documentation can be submitted as part of the dispute process. A final determination will be made by the State Programs Unit Lead within ten (10) business days after receipt of the dispute. If the provider disagrees with the dispute determination made by the State Programs Unit Lead, the provider may file an appeal directly to the Special Financing Division Director within three (3) business days after receiving the final dispute determination from the State Programs Unit Lead. The appeal shall be sent to hcpf_CICPCorrespondence@state.co.us.

Following receipt of the appeal, the Special Financing Division Director will perform a review. As part of this review, the Special Financing Division Director will gather documents and information from the State Programs Unit Lead specific to their final determination. No new data, information, or documentation can be submitted as part of the dispute process. A final decision will be made by the Special Financing Division Director within five (5) business days after receipt of the dispute. If the provider disagrees with the dispute determination made by the Special Financing Division Director, the provider may file an appeal directly to the Executive Director within three (3) business days after receiving the final dispute determination from the Special Financing Division Director. The appeal shall be sent to hcpf_CICPCorrespondence@state.co.us.

A final determination will be made by the Executive Director within five (5) business days after receipt of the appeal. The decision of the Executive Director is final.

ARTICLE III. PROVIDER COMPLIANCE AUDIT REQUIREMENTS

Section 3.01 Eligibility Audit

The goal of the Eligibility audit is to ensure that each CICP applicant's eligibility determination was made correctly under the regulations specified in the CICP Manual and that the provider has the appropriate supporting documentation on file.

To choose the files for this portion of the audit, the auditor will need a list of all applications completed by the facility and its satellites during the program year. Providers must provide a list of all completed applications (including applications for clients who were denied) from the program year. The list can be pulled from the provider's eligibility system or, if the system cannot generate that kind of report, the provider should be compiling a list of applications completed throughout the year in an easily accessible format (Excel, Word, etc.)

The following items are examined to verify a client's eligibility status:

1. Verification that the audit candidate is able to supply an original application for each of the clients selected in the audit sample.
2. Verification that the application was signed and dated by all required parties in all relevant fields.
3. Verification that if the applicant is over the age of 18, they have:
   a. Signed the Lawful Presence Affidavit indicating lawful presence status
   b. Provided one approved document demonstrating their lawful presence status
   c. Demonstrated that they are a Colorado resident
   d. Furnished a Social Security number
   e. Verification that if a client is a non-U.S. citizen and did not supply an ID card issued by a REAL ID Act compliant state, that the appropriate SAVE or other documentation is available.
4. Verification that the income determination was accurately completed and can be confirmed by reviewing the required supporting documentation.
   a. For all working applicants (excluding self-employed applicants) a copy of paycheck stubs is on file.
   b. If the provider made an income determination without supporting documentation, evidence that a reasonable effort was made to obtain the information must be documented.
   c. Verification that the appropriate Ability-to-Pay scale was utilized based on income determination and that the correct CICP maximum copay rate was calculated.
5. Verification that the client was not eligible for Health First Colorado or CHP+ and that the appropriate denial letters or other relevant supporting documentation is present with the application.

Section 3.02 Billing Audit

The Billing portion of the audit examines a sample of the provider's billing records to verify that patients were charged appropriately according to their CICP rating and that charges and payment information was translated correctly into the totals that were reported to the Department in the CICP Provider Application.

The following items are reviewed as part of the Billing Audit:

1. Verification that billing records for client selected in the audit sample are available within the provider's billing system or other archive.
2. Verification that the client was eligible for the CICP. Documentation could include a copy of the CICP application or copy of the client's CICP card.
3. If applicable, verification that reimbursement was sought from a third party associated with the relevant client prior to billing the CICP.
4. Verification that the patient was charged the correct copayment based on the sliding fee scale.
5. Verification that the total charge for the service was the same charge billed to non-CICP patients during the same period.