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We have completed an audit of the Division of Health Care Financing and Policy. This audit is part of the ongoing program of the Legislative Auditor as authorized by the Legislative Commission. The purpose of legislative audits is to improve state government by providing the Legislature, state officials, and Nevada citizens with independent and reliable information about the operations of state agencies, programs, activities, and functions. The results of our audit, including findings, conclusions, recommendations, and the Division's response, are presented in this report.

We wish to express our appreciation to the management and staff of the Division of Health Care Financing and Policy for their assistance during the audit.

Respectfully presented,

Paul V. Townsend, CPA
Legislative Auditor

January 23, 2008
Carson City, Nevada

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY

AUDIT REPORT

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EXECUTIVE SUMMARY

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY

Background

Title XIX of the Social Security Act is a federal and state entitlement program, known as Medicaid, that pays for medical assistance for certain individuals and families with low incomes and resources. Nevada adopted the Medicaid program in 1967 with the passage of legislation placing the Medicaid program in the Welfare Division (currently the Division of Welfare and Supportive Services). The Division of Health Care Financing and Policy (HCF&P) was created during the 1997 legislative session and began administration of the Medicaid program on July 1, 1997. HCF&P administers two major federal health coverage programs, Medicaid and the State Children's Health Insurance Program known as Nevada Check Up.

In general, Nevada makes program services available to low-income persons who are aged, blind, or disabled and to women and children. Total recipients for Medicaid and Nevada Check Up for fiscal year 2007 were 168,198 and 28,364 respectively. Medical costs for these recipients over the same time period amounted to approximately $1.2 billion and $38 million respectively. For the most part, federal funds are matched with general fund appropriations. In fiscal year 2007 the Federal government paid 54.14% of most medical costs and 50% for administrative costs. Other enhanced rates are available for specific types of expenditures.

Purpose

The purpose of this audit was to determine if HCF&P's Compliance Unit had sufficient procedures to identify fraud, abuse, and over-utilization to ensure control over medical payments. Further, this audit also determined if controls existed to ensure fee-for-service payments for

certain managed care enrollees were appropriate. Our audit included the Compliance Unit's activities for fiscal year 2006, although extended testing was performed back to fiscal year 2004 in certain instances. Our review of managed care controls included the period January 2004 to June 2006.

Results in Brief

HCF&P had not implemented sufficient procedures to identify improper Medicaid payments resulting from fraud, abuse, or non-compliance with established billing procedures. As a result, our review of certain high risk claims found about $19 million in overpayments and errors. In addition, we estimate HCF&P may have overpaid almost $5 million for certain billing procedure codes that lacked sufficient detail to determine if the charges were appropriate. Overpayments and errors resulted from improper billings, claims payment system problems, and inadequate review of known areas of high risk. Furthermore, HCF&P had not implemented sufficient procedures to monitor and review the managed care enrollment process for newborns. This lack of control has allowed HCF&P to pay about $4.4 million in claims that should have been paid by the managed care organizations. Because HCF&P must also pay managed care organizations a monthly coverage charge for these recipients, it is duplicating medical coverage. Better monitoring, review, and the development of policies and procedures will help HCF&P alleviate these issues.

Principal Findings

- HCF&P did not adequately monitor or review claims paid as a percentage of the amount billed by providers. As a result, HCF&P paid providers about $16 million more than they should have. This occurred because providers billed at rates higher than amounts specified in policy. Because the system

assumed the amounts billed by providers were accurate and little or no controls existed to ensure payments were proper, significant overpayments resulted. (page 15)

- HCF&P did not monitor or limit the manner or amount in which two unlisted drug codes were used. These procedure codes were too general to determine if the amounts billed were appropriate. Specifically, two unlisted drug procedure codes were billed nearly 35,000 times in fiscal year 2006. The next 10 highest drug procedure codes were billed about 6,000 times in total. Furthermore, these procedures were paid based on a percentage of the providers' billed charges which may have resulted in significant overpayments. As a result, we estimate HCF&P could have paid about $4.8 million more than necessary for these drugs. (page 18)

- The number of units billed for certain drugs were not always reasonable. We found 16 claims for a drug used for the management of renal disease (Epoetin Alfa) with monthly dosages ranging from 570 to 3,360 per recipient. Medicare literature states the maximum dosage for this drug over a month's time is 500 units. Our calculations indicate HCF&P paid at least $932,000 more than necessary for these claims. (page 20)

- An improper rate for an inpatient hospital charge was entered into the claims payment system. The published rate indicated claims should have been paid at $250 per day for this charge; however, the claims payment system paid claims at $1,345 per day. As a result, over 200 claims were paid at the improper rate, resulting in nearly $1 million in overpayments to hospitals. This occurred because HCF&P did not have policies and procedures over rate changes to the claims payment system. (page 22)

- Keying errors on claims and other data entry resulted in inappropriate payments and the insufficient request of federal funds. For instance, a cash receipt, which reduced total medical payments was entered as $903,903.80 instead of $903.80. As a result, HCF&P's quarterly medical costs were reduced by the keying error. Therefore, HCF&P did not recover about $500,000 in matching federal funds until we brought the error to management's attention. (page 23)

- HCF&P inappropriately paid claims for services on recipients who were covered by Medicare. This resulted in thousands of dollars that were not properly recovered or were paid needlessly because Medicare should have covered a majority of the costs. This occurred because controls did not properly identify recipients with Medicare coverage. Further, payments were made because the claims payment system processed improper claim forms and an inappropriate edit was entered in the system. After we brought these errors to HCF&P's attention, management initiated a process to recover these overpayments with a contractor who will be paid 12% of the recoveries. In September 2007, HCF&P provided information indicating it had initiated recovery of $6.6 million. While a portion of this recovery can be attributed to the payment of claims by Medicare, a significant amount is due to HCF&P's overpayment of claims because of payment methods and other problems previously noted. (page 24)

- HCF&P's Compliance Unit, responsible for the identification of fraud, abuse, and over-utilization, did not adequately identify erroneous payments in fiscal year 2006. Based on a review of recoveries that occurred during this time, the Compliance Unit recovered less than $1.7 million, which is less than ½ of 1% of medical payments for the year. While a specific estimate of fraud, abuse, and over-utilization in Medicaid programs is hard to determine, it is

generally considered to be more than 1%. California estimated fraud to be over 3%, and total payment errors to be over 8% of fiscal year 2005 payments. (page 28)

- Payments for medical services were inappropriately paid for newborns who should have been enrolled and covered by managed care organizations. Based on reports generated by HCF&P, these payments amounted to $4.4 million. Furthermore, the managed care organization contracts state monthly coverage payments are due for the month of birth and subsequent months the child is program eligible and enrolled with the managed care organization. As a result, HCF&P could be liable for as much as $2.6 million in additional payments for these newborn recipients. This occurred because HCF&P's claims payment system failed to enroll newborns properly and HCF&P did not have a compensating process in place to monitor, review, and change this information as necessary. (page 31)

- Additional controls regarding managed care activities can assure improper payments do not continue to occur. Policies and procedures had not been established to ensure providers did not submit duplicate claims to HCF&P and the managed care organization. Further, prior authorizations for certain hospital procedures did not include a determination of whether the recipients should have been enrolled in managed care. Finally, procedures are necessary to ensure monthly coverage payments made to managed care organizations are proper. (page 33)

Recommendations

This report contains 18 recommendations to improve controls over Compliance Unit activities and prevent inappropriate payments for managed care enrollees.

Specifically, we made seven recommendations for improvements to controls including additional monitoring and review of processes. Further, we made four recommendations regarding the development of policies and procedures to guide HCF&P activities. Additionally, we made seven recommendations including improvements to the claims payment system, enforcing existing policies and procedures, performing necessary reviews of data, and strengthening current processes. (page 49)

Agency Response

The Division, in response to our report, accepted the 18 recommendations. (page 41)

Introduction

Background

Title XIX of the Social Security Act is a federal and state entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 to assist states in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's poorest people.

Nevada adopted the Medicaid program in 1967 with the passage of state legislation placing the Medicaid program in the Welfare Division (currently the Division of Welfare and Supportive Services). The Division of Health Care Financing and Policy (HCF&P) was created during the 1997 legislative session and began administration of the Medicaid program on July 1, 1997. HCF&P administers two major federal health coverage programs, Medicaid and the State Children's Health Insurance Program (SCHIP). The SCHIP is known as Nevada Check Up and provides healthcare coverage to low-income, uninsured children who are not eligible for Medicaid.

The mission of HCF&P is to purchase and provide quality health care services to low-income Nevadans in the most efficient manner; promote equal access to health care at an affordable cost to taxpayers of Nevada; restrain growth of health care costs; and review Medicaid and other state health care programs to maximize federal revenue.

States have broad discretion in determining which groups the Medicaid programs will cover and the financial criteria for Medicaid eligibility. In general, Nevada makes program services available to low-income persons who are aged, blind or disabled, and to women and children. The Division of Welfare and Supportive Services is responsible for determining Medicaid eligibility. Exhibit 1 shows the annual average monthly eligible Medicaid and Nevada Check Up recipients by aid group for fiscal years 2003 to 2007.

Exhibit 1

Annual Average Monthly Recipients
By Aid Group
Fiscal Years 2003 to 2007

Aid Group	2003	2004	2005	2006	2007
TANF[(1)]	89,831	92,885	92,435	87,555	80,721
CHAP[(1)]	24,495	26,627	26,752	27,912	29,036
Aged	9,404	9,841	10,125	10,445	10,795
Blind/Disabled	22,865	24,522	25,111	25,453	25,655
QMB/SLMB[(1)]	10,813	12,531	12,683	12,557	13,300
Child Welfare	4,966	5,139	5,887	7,301	7,180
County Match	1,410	1,346	1,409	1,462	1,511
Total Medicaid	**163,784**	**172,891**	**174,402**	**172,685**	**168,198**
NV Check Up	**24,782**	**25,025**	**26,750**	**27,492**	**28,364**

Source: Division of Health Care Financing and Policy Medicaid and Nevada Check Up Fact Book, January 2007, and HCF&P records.

[(1)]TANF = Temporary Assistance for Needy Families, CHAP = Child Health Assistance Program, QMB = Qualified Medicare Beneficiary, SLMB = Specified Low-Income Medicare Beneficiary.

Within federal guidelines, states determine the amount, duration, and scope of services offered under their Medicaid programs, sufficient to reasonably achieve its purpose. Exhibit 2 shows total medical costs for Medicaid and Nevada Check Up for fiscal years 2003 to 2007. Further detailed information regarding Medicaid costs by medical category for fiscal year 2006 and 2007 can be found in Appendix B.

Exhibit 2

Total Medical Costs
Medicaid and Nevada Check Up
Fiscal Years 2003 to 2007

	2003	2004	2005	2006	2007
Medicaid	$853,361,913	$971,230,000	$1,177,397,578	$1,167,629,527	$1,221,762,268
NV Check Up	$ 32,884,093	$ 27,866,758	$ 32,756,685	$ 34,894,464	$ 38,006,413

Source: Division of Health Care Financing and Policy Medicaid and Nevada Check Up Fact Book, January 2007, and HCF&P records.

HCF&P is under contract with First Health Service Corporation, a fiscal agent who is responsible for the prompt and proper processing of all claim payments for covered services in accordance with policies and procedures established by Nevada Medicaid. The fiscal agent is also responsible for performing provider enrollment and training, maintaining files for providers and recipients, issuing prior authorizations for

specified services, adjudicating claims and performing claim adjustments, processing point-of sale pharmacy claims, and recovering third-party payment when applicable.

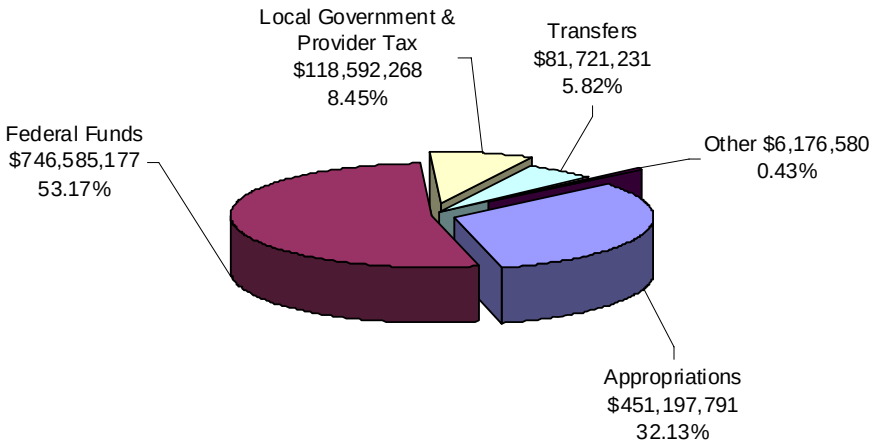
Budget and Staffing

The Medicaid program is a jointly funded cooperative venture between the federal and state governments to assist in the provision of adequate medical care to eligible needy persons. Federal Financial Participation (FFP) is composed of two parts, the administrative FFP which is generally 50%, and the Federal Medical Assistance Percentage (FMAP) which is evaluated annually based on the per capita income of each state. Enhanced administrative FFP is available for skilled medical professionals (75%), operation of federally certified Medicaid Management Information Systems (MMIS) (75%), and design development and implementation of an MMIS system (90%). The FMAP rate for state fiscal year 2006 was 55.05%. The rate for fiscal year 2007 was 54.14% with enhanced FMAP available for family planning services (90%), payment to Indian Health Services (100%), and coverage of individuals under the Breast and Cervical Cancer program (65%).

For the most part, federal funds are matched with general fund appropriations. However, HCF&P does use other funding sources to match federal funds. This includes a nursing facility tax used to enhance rates to facilities and funds from counties used for costs associated with certain institutionalized individuals. HCF&P oversaw seven budget accounts in fiscal year 2007. Exhibit 3 shows the Division's total revenues by type and Exhibit 4 shows total expenditures by category for fiscal year 2007.

Exhibit 3

Total Revenues
Fiscal Year 2007

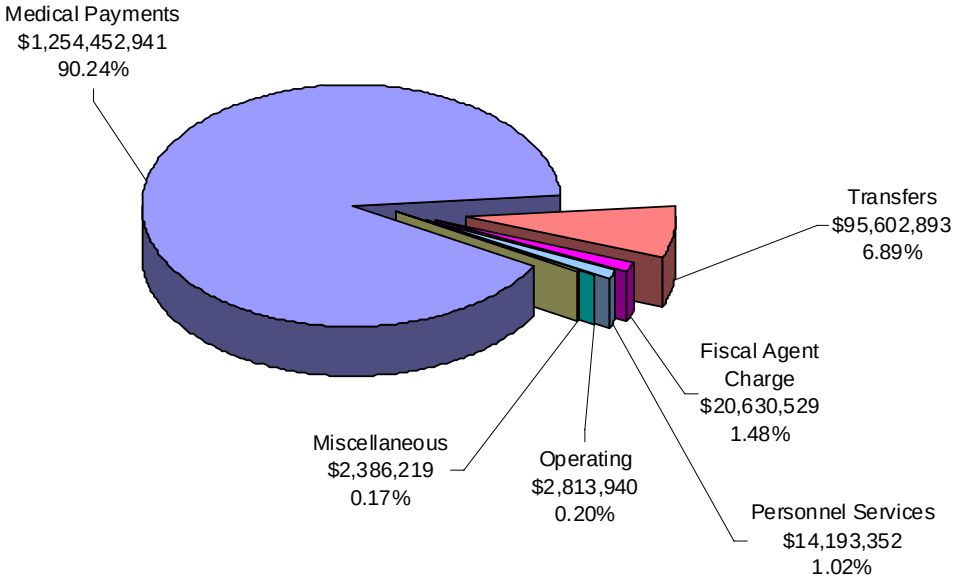


Source: State Accounting System.

Note: Other revenues include health cost containment fee, audit fees, administration fees, civil penalties and other amounts that were public funding sources. Revenues do not include funds balanced forward from prior year. General Fund appropriations were netted with amounts reverted.

Exhibit 4

Expenditures by Category
Fiscal Year 2007



Source: State Accounting System.

Note: Miscellaneous expenditures include training, utilities, purchasing assessments, Statewide and AG cost allocations, and other amounts not able to be categorized in the descriptions noted above.

HCF&P's administrative office is located in Carson City. The Division also has district offices in Carson City, Elko, Henderson/Las Vegas, and Reno. During fiscal year 2007, the Division had 241 authorized positions and the following units and programs:

- Administration
- Administrative Services
- Compliance
- Continuum of Care
- Medicaid
- Nevada Check Up and Health Insurance Flexibility and Affordability Waiver
- Information Systems
- Managed Care/Business Lines
- Program Services

Our audit concentrated on the Compliance and Managed Care Units' activities.

Compliance Unit

The Compliance Unit's responsibilities include overseeing the development of Division policy with respect to the provision and delivery of goods and services; providing information about access, goods, services and processes of Medicaid assistance to customers; and preserving and maintaining the financial integrity of the Medicaid program. This includes a statewide Surveillance and Utilization Review System (SURS) that is required to provide safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments; assess the quality of those services; and provide controls for the utilization of all services provided under the Medicaid program. Personnel in the SURS area are also responsible for identifying, investigating, and referring suspected fraud and abuse cases to the Office of the Attorney General, Medicaid Fraud Control Unit. SURS employees are authorized to seek recovery or impose administrative actions for fraud or abuse cases. HCF&P defines fraud in part, as, "An intentional misrepresentation of truth for the purpose of inducing another in reliance upon it to part with some valuable thing belonging to him or to surrender a legal right." Abuse is defined as, ". . . provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically

necessary or fail to meet professionally recognized standards for health care. No intent is required."

Managed Care

Nevada Medicaid administers both fee-for-service and managed care programs. HCF&P contracts for delivery of health care through managed care organizations for certain Medicaid and Nevada Check Up populations. The objectives of the program are to improve access and coordination of care while managing the cost of services. Enrollment in a managed care plan is mandatory in Clark and Washoe counties for certain aid groups. Services provided through the managed care plans include dental, as well as, medical care. Combined statewide Medicaid and Nevada Check Up enrollment is over 100,000 members.

HCF&P re-bid its managed care contracts during fiscal year 2007. Health Plan of Nevada and Anthem Blue Cross Blue Shield Partnership Plan currently are the managed care organizations providing services. Prior to Anthem, Nevada Care provided services as one of the contracted organizations.

Scope and Objectives

This audit is part of the ongoing program of the Legislative Auditor as authorized by the Legislative Commission, and was made pursuant to the provisions of NRS 218.737 to 218.893. The Legislative Auditor conducts audits as part of the Legislature's oversight responsibility for public programs. The purpose of legislative audits is to improve state government by providing the Legislature, state officials, and Nevada citizens with independent and reliable information about the operations of state agencies, programs, activities, and functions.

This audit included a review of HCF&P's Compliance Unit's activities and the managed care enrollment process for newborns. The scope of our testing included fiscal year 2006 for Compliance Unit activities although extended testing was performed back to fiscal year 2004 in certain instances. Our scope for managed care testing included the period from January 2004 to June 2006. The objectives of our audit were to determine if:

- the Compliance Unit's Survey Utilization Review System had sufficient procedures to identify fraud, abuse, and over-utilization to ensure control over medical payments; and,
- controls existed to ensure fee-for-service payments for certain managed care enrollees were appropriate.

Findings and Recommendations

HCF&P had not implemented sufficient procedures to identify improper Medicaid payments resulting from fraud, abuse, or non-compliance with established billing procedures. As a result, our review of certain high risk claims found about $19 million in overpayments and errors. In addition, we estimate HCF&P may have overpaid almost $5 million for certain billing procedure codes that lacked sufficient detail to determine if the charges were appropriate. Overpayments and errors resulted from improper billings, claims payment system problems, and inadequate review of known areas of high risk. Furthermore, HCF&P had not implemented sufficient procedures to monitor and review the managed care enrollment process for newborns. This lack of control has allowed HCF&P to pay about $4.4 million in claims that should have been paid by the managed care organizations. Because HCF&P must also pay managed care organizations a monthly coverage charge for these recipients, it is duplicating medical coverage. Better monitoring, review, and the development of policies and procedures will help HCF&P alleviate these issues.

HCF&P Needs to Strengthen Its Compliance Unit

HCF&P's unit responsible for identifying fraud, abuse, and over-utilization has not implemented adequate procedures to provide reasonable assurance medical claims are appropriate. Overpayments of approximately $17.3 million were identified through claims analysis of high risk areas. We also estimate certain claims with insufficient billing information may have been overpaid by $4.8 million. Furthermore, we discovered system processing errors that resulted in the insufficient recovery, or inappropriate payment of at least $1.6 million. Overpayments resulted from providers billing amounts in excess of established policies and billing excessive units. In addition, appropriate billing rates, system edits, and adequate controls, including policies and procedures, had not been established.

Excessive Payments Resulted From Improper Billings and a Lack of Review

Improved oversight by HCF&P is necessary to ensure payments of high risk claims are proper. Certain claims known to be at risk for inappropriate payment were not monitored by HCF&P. As a result, significant overpayments were paid to providers. We estimate millions of dollars in claims were overpaid because providers did not bill in accordance with HCF&P policies, generic drug procedure codes were not sufficient to verify the billing rates, and no oversight or corrective action was performed by HCF&P.

Failure to Bill in Accordance With Policy Resulted in Significant Overpayments

HCF&P pays claims for some services as a percentage of the charges billed by the provider. While policies specify amounts that providers must bill, this was rarely followed. Paying claims by this method relies on the provider to bill the correct amount; however, there were no system or manual controls in place to ensure billed amounts were appropriate. As a result, HCF&P paid providers about $16 million more than they should have. Because HCF&P had not established fixed rates for many of the procedures we reviewed, we used rates paid by Medicare as our benchmark. While the majority of the procedures tested were related to drugs administered by physicians' offices, independent facilities, and hospitals, we found other procedures where payments appeared excessive.

An analysis of medical costs paid from fiscal year 2002 to 2006 showed a significant increase in cost per recipient for End Stage Renal Disease (ESRD) services. Exhibit 5 shows the total claims payments for fiscal years 2002 to 2006, as well as, cost per recipient for ESRD services.

Exhibit 5

End Stage Renal Disease Medical Services
Fiscal Years 2002 to 2006

	2002	2003	2004	2005	2006
Total Medical Costs	$2,725,709	$3,342,289	$3,700,762	$12,059,652	$17,236,619
Yearly % Increase	n/a	22.62%	10.73%	225.87%	42.93%
Cost Per Recipient	$ 6,616	$ 7,219	$ 7,090	$ 19,173	$ 28,350
Yearly % Increase (Decrease)	n/a	9.11%	(1.79)%	170.42%	47.86%

Source: HCF&P claims payment and report generation systems.

Discussions with HCF&P personnel indicate costs increased for ESRD related services due to a change in the method in which claims were paid. Prior to the new claims

payment system, claims were manually reviewed, calculated, and paid. However, when the new claims payment system was brought online in October 2003, some procedures were paid as a percentage of the charges billed by the provider. Currently, HCF&P pays approximately 1,300 procedures at either 62% or 85% of the billed charges.

In an effort to control the charges billed by a provider, HCF&P policy states that providers must bill the average wholesale price for drugs as published in a specified publication. However, drugs we reviewed were rarely billed at the published price. For example, one drug used for the management of renal disease – Epoetin Alfa – was usually paid at a cost per unit that exceeded the amount that would have been paid if providers billed according to HCF&P policy. Of the 50 claims tested for ESRD services, 19 were specific to the drug Epoetin Alfa. Each of these claims billed at unit prices that exceeded the average wholesale price. Providers for these 19 claims billed between $96 and $1,204 per drug unit on these claims. However, HCF&P policy required providers bill at a price per unit of about $12. Consequently, we obtained information on all claims paid for this drug for fiscal years 2004, 2005, and 2006.

Our analysis of all claims paid during the 3 fiscal years showed 90% were paid at a price of $25 or more per drug unit. While the majority of the claims were paid in amounts ranging from $25 to $125 per unit, we found multiple claims where the per unit amount paid exceeded $1,000 and two that exceeded $10,000. Exhibit 6 shows the frequency of claims for the drug Epoetin Alfa paid in fiscal years 2004, 2005, and 2006, that exceeded a unit billing price of $12.

Exhibit 6

Epoetin Alfa Claims Paid in Fiscal Years 2004, 2005, and 2006 Exceeding $12 Per Unit Billed

Unit Price Billed	Unit Price Paid	Number of Claims	Percent of Total
$ 13.00 - $ 29.41	$ 11.00 - $ 25.00	595	9.80%
$ 29.42 - $ 88.24	$ 25.01 - $ 75.00	1,143	18.82%
$ 88.25 - $ 147.06	$ 75.01 - $ 125.00	3,893	64.09%
$ 147.07 - $ 588.24	$ 125.01 - $ 500.00	216	3.56%
$ 588.25 - $1,058.82	$ 500.01 - $ 900.00	72	1.18%
$1,058.83 - $2,352.94	$ 900.01 - $2,000.00	151	2.48%
$2,352.95 & Up	$2,000.01 & Up	4	.07%

Source: HCF&P reports from the claims payment system.

As a result of providers billing excessive amounts for this drug, HCF&P overpaid providers approximately $11 million for these 3 fiscal years, or roughly 84% of the $13 million in total payments.

We also found about $5.5 million in overpayments for other drugs due to payment methods that relied on provider accuracy. Because more than 1,300 procedure codes are paid as a percentage of the amount billed, we tested an additional 10 drugs to determine the extent of the problems related to this payment method. For the 50 claims tested related to these drugs, 46 were paid at excessive amounts. Some providers billed two times the unit value that policy dictated while others billed approximately 180 times that amount. For instance, one provider billed almost $11,000 per unit for a drug while the amount that should have been billed was approximately $60.

Additionally, providers did not always bill the same unit price for the same drug and increased their drug unit prices consistently over time. For example, one provider billed a per unit price for 8 claims at under $10 per unit, 12 claims at $58 per unit, and another claim at $518 per unit. Furthermore, the per unit drug price for one provider increased 63% during fiscal year 2006. During the same time period, the Medicare reimbursement rate for this drug slightly decreased. These errors resulted in overpayments to providers.

Furthermore, our review of ESRD claims found that other services were also overpaid. Twenty-seven of the 50 claims reviewed were for payments related to the administration of ESRD services. Of these 27 claims reviewed, 13 were paid at rates higher than that paid by Medicare. HCF&P paid between $496 and $754 for each day services were administered. Conversely, Medicare would have paid between $132 and $220 per day. Because ESRD services are administered about 13 times per month, excessive per day payments add up over time. HCF&P staff indicated rate setting for these services are complicated because administration services include many factors. However, HCF&P has set rates for other ESRD administration related procedure codes. While setting rates may be complicated and cumbersome, they are necessary to contain costs.

Providers were allowed to bill amounts in excess of policy because HCF&P did not have controls in place to ensure billings were appropriate. Further, when payments are based on a percentage of the provider billed charges, the claims payment system does not apply the same edits to the claims as it does when rates are fixed. Therefore, not setting rates increases the risk of inappropriate payments; however, HCF&P did not review claims during the period they were in effect from October 2003 to the present.

On September 20, 2007, we met with staff from the Attorney General's Medicaid Fraud Control Unit to discuss certain issues regarding claims paid as a percentage of providers' billed charges. In addition, we provided data regarding these payments to them as requested during that meeting.

Unlisted Procedure Codes Increase Risk of Overpayment

HCF&P was not always able to determine if the amounts billed by providers using unlisted procedure codes were appropriate. This occurred when claims were submitted using procedure codes that were too general to determine if amounts billed were proper. Further, these procedure codes were paid based on a percentage of the amounts providers billed, making these claims a high risk for overpayment, fraud, and abuse. However, HCF&P did not monitor or limit the manner or amount in which these codes were used. As a result, we estimate HCF&P may have paid about $4.8 million more than it should have for these procedure codes.

During fiscal year 2006, HCF&P paid claims totaling more than $6 million for two drug procedure codes. These codes titled, oral prescription drug non-chemo and drugs unclassified injection, lacked appropriate detail to determine the exact drug administered by the provider. As a result, amounts and units billed by providers could not be compared to supporting documentation to determine their adequacy. Because of this, these procedure codes should be allowed on a limited basis and only if the drug administered does not have a specific code to bill under. HCF&P allows billings for hundreds of drug specific codes; however, data generated by HCF&P show these two procedure codes were billed in excess of 35,000 times during 2006. The next 10 highest drug procedure codes were billed about 6,000 times in total.

Additionally, HCF&P paid these drug procedure codes based on the amount billed by providers. Without sufficient information to determine the drug administered,

HCF&P cannot determine if amounts billed and subsequently paid are proper. While the majority of billings we reviewed were for unit costs of less than $500, there is no way to determine the appropriateness of these charges. Overpayments for the other 10 drugs we examined averaged 80% of the amount paid. Therefore, based on that percentage, we estimate HCF&P could have paid about $4.8 million more than necessary for these drugs during fiscal year 2006.

HCF&P did not identify or monitor these procedures at increased risk for overpayment, fraud, or abuse. Even though the Compliance Unit is responsible for controlling utilization and preventing excess payments, it did not have procedures requiring the identification of, and ongoing periodic review of these areas. Procedures should include routine monitoring and assessment of the necessity of using unlisted procedure codes for services. In addition, controls limiting the use of these codes are necessary to ensuring utilization is proper. Finally, further investigation into provider billing amounts is essential to identifying and recovering overpayments.

Problems Known to HCF&P

Paying claims based on provider billed charges increases the risk of inappropriate payments because the claim payment system presumes the billed amounts are correct. Compounding the problem was a lack of compensating controls such as claim review and analysis. Furthermore, overpayments continued even though HCF&P was notified by a provider they were occurring. Establishing fixed rates and implementing controls over procedures paid by this method are essential to ensuring payments are proper.

Relying on providers to bill properly without any compensating edits in the claims payment system is risky. Providers often bill a usual and customary fee when they request payment for services rendered. Therefore, compensating controls are necessary to ensure providers bill the proper amount. However, HCF&P did not adequately review claims paid in this manner even when a provider notified the agency about being overpaid.

HCF&P staff indicated early in our audit that cost increases for certain medical categories could be due to claims paid as a percentage of the amount billed by the provider. Staff indicated rates were set to pay by this method because Medicare did not

have comparable rates at the time the claims payment system was brought online in October 2003. While setting rates in this manner may have been justified, we found Medicare had fixed rates for many of the procedures codes since January 2005. Our review of these rates indicates the fixed Medicare rates were similar to what HCF&P would have paid if providers billed in accordance with policy. Yet, HCF&P continued to pay many of these procedure codes based on a percentage of the providers' bills. Staff indicated some rates have been established to provide maximum payment amounts on these claims; however, many procedures continue to be paid in this manner.

Additional Edits Needed to Contain Costs

HCF&P can diminish erroneous claims by adding edits to the claims payment system. During our review, certain claims were paid because edits to monitor units billed, ensure monthly billings, and review claims for reasonableness did not exist. This oversight resulted in almost a million dollars being paid to providers for services that were medically improbable. Although HCF&P did add one edit to the system during our audit, additional edits are necessary to prevent erroneous and high dollar claims from paying automatically.

Units Billed Not Always Reasonable

Edits regarding the drug dosages administered by physicians, independent facilities, and hospitals are necessary to ensure the number of units billed are reasonable; however, these edits had not been established. As a result, providers submitted bills for Epoetin Alfa in which the number of units administered were not medically probable. For instance, we found 16 claims for this drug with billing units ranging between 570 and 3,360 per recipient for a month's service. Based on literature from Medicare, billing dosages exceeding 500 for this time period are considered to be medically unbelievable. Our calculations indicate HCF&P paid at least $932,000 more than necessary for these claims.

During our audit, HCF&P did request an edit be placed in the claims payment system to limit the monthly billable dosage of this drug. This edit would check claims for a maximum dosage of 500 units for monthly services. Additionally, HCF&P requested claims paid for services rendered after January 2006 be reprocessed, and those with unit limits over the edit threshold be set aside for medical review.

We also found the number of billed drug units were not always reasonable or consistent. For example, some claims were paid even though the claims did not include the number of units administered. In addition, units noted on drug claims were not always consistent with literature or units billed by other providers. For instance, one claim we reviewed was for a drug that was administered based on the weight of the patient. Based on the units shown on the claim, and the drug conversion, the patient exceeded 600 pounds. While this dose may have been reasonable, the system lacked any edits to flag this type of claim for review. Additionally, some providers billed consistently more units than others. For one drug, all but one provider usually billed between 5 and 10 units; yet, one provider billed anywhere from 10 to 90 units per claim. This provider's billings were paid, even though the units billed appeared excessive, because the claims payment system does not review the number of units billed or other necessary information prior to payment. As fixed rates are placed in the system for these procedures, edits for unit totals become more important. While several factors may affect the number of units administered to a particular patient, maximum unit edits should be based on drug administration dosages that are reasonable for most patients.

Monthly Bills Required for Certain Facilities

HCF&P requires certain facilities to bill on a monthly basis; however, some facilities submitted bills on a daily basis instead. Four of the 50 claims we reviewed for ESRD services were found to have been billed per day instead of by month. For instance, one facility billed on a daily basis for a recipient who had drugs administered for ESRD treatment. When the billed drug units were totaled for each day the facility billed for during a month, the total units billed exceeded the maximum dosage threshold for 10 of the months paid in fiscal year 2006. The claims payment system did not edit claims for service periods to ensure providers billed according to policy. Billing on a daily basis circumvents edits that are based on monthly dosage limitations. Additionally, billing for daily services means more claims are processed by the fiscal intermediary which can result in additional costs.

Large Claims Need Monitoring

HCF&P had not established sufficient maximum pay thresholds for most services. For 3 of the 50 ESRD claims tested, HCF&P paid more than $100,000 for each claim. The largest claim payment was more than $274,000. These three claims were overpaid by thousands of dollars because of excessive rates and units as previously discussed. HCF&P does have system edits that require manual review for inpatient and outpatient hospital claims exceeding a certain threshold. However, these are the only services requiring such a review for high dollar payments. While claims for ESRD services were significantly overpaid because system and other compensating controls were lacking, maximum pay thresholds may have allowed HCF&P to discover the significance of these problems sooner.

Fraud and Abuse Reviews Can Also Identify Claim Processing Errors

Review of high risk claims can identify weaknesses in claims processing not related to fraud, abuse, or over-utilization. By reviewing claims in areas identified as high risk, we found claims processing and administrative control deficiencies that resulted in the insufficient recovery of matching federal dollars or erroneous payments to providers totaling about $1.6 million. Weaknesses included paying claims at inappropriate rates, keying errors, not recovering or requiring payment from other sources, and inaccurate claim overrides. The implementation of additional controls to review and monitor activities should help prevent and detect these errors from occurring in the future.

An Incorrect Rate Caused Overpayments

In order to determine if medical claims are being paid accurately by the claims payment system, they must be periodically reviewed. Our review of high dollar claims, which consisted mainly of inpatient hospital charges, found certain claims were not paid at the proper rate resulting in almost $1 million in overpayments.

HCF&P pays inpatient hospital charges based on a per day rate which is tied to the type of bed occupied by the patient. Rates increase for more intensive levels of care. For instance, rates effective in January 2006 showed the highest rate, associated with trauma level care, was paid at a rate of $2,200 per day; while, the lowest rate was $180 for an intermediate administrative bed day.

Our review of one hospital claim found that the claim paid at a different rate than was published by HCF&P. The published rate indicated the claim should be paid at $250 per bed day; however, the claims payment system paid the claim at $1,345 per day. This occurred because an improper rate for an administrative bed day was requested and placed in the claims payment system. The claims payment change form, dated October 2003, requested the rate for an administrative bed day be $1,345; yet, HCF&P publicized the rate at $250. The rate error was inadvertently corrected in December 2003 when HCF&P requested the administrative bed day billing code be changed with a rate of $250. Discussions with staff indicate HCF&P was unaware an incorrect rate had been established in the system for this time period. As a result, approximately $962,000 was improperly paid to hospitals on 205 claims during this time period.

These overpayments occurred because HCF&P did not have sufficient controls over rates added to the claims payment system. Specifically, HCF&P did not have policies and procedures over rate changes to the claims payment system. Controls should include a comparison of prior rates to requested changes, review of documentation supporting new rates, and review and approval of the change request form by supervisory personnel.

Keying Errors Problematic

Even though HCF&P's claims payment system is designed to capture and process data electronically, some data is still manually entered into the system. During our audit, we found keying errors on claims and other data entry that resulted in the loss of hundreds of thousands of dollars. The occurrence of these errors can be mitigated with increased controls and proper reviews.

Providers may send checks to HCF&P when they have collected more payment than they are due. This can occur when providers receive payment from Medicaid and later receive reimbursement from another insurer such as Medicare. When this happens, HCF&P's fiscal agent enters cash receipt information into the claims payment system to offset the original claim payment. These entries reduce total medical expenses claimed on federal reimbursement reports.

During our review of claim data, we found a keying error related to the receipt of a provider payment. A provider remitted funds of $903.80 because an additional payment had been received in September 2005. The receipt was entered into the claims payment system incorrectly at $903,903.80; therefore, medical costs were reduced by the amount entered in the system, not the actual cash receipt total. When HCF&P requested reimbursement for medical services on their quarterly federal report, they used the expenditure totals from the claims payment system. As a result, HCF&P did not recover about $500,000 in matching federal dollars. This error happened because HCF&P did not have adequate controls in place to detect and prevent keying errors when the error occurred. Subsequently, HCF&P did implement some review of manual inputs related to cash receipts and corrected this error on the June 2007 quarterly report; but, additional controls and review are necessary to ensure keying errors are detected in the future.

Keying errors on claims also resulted in inaccurate payments to providers. Claims are submitted to HCF&P electronically or by the traditional paper method. Paper claims are submitted to HCF&P's fiscal intermediary and are manually entered into the claims payment system. We found 3 of the 29 paper claims in our sample had keying errors. These errors resulted in overpayments to providers of almost $24,000. In one instance, HCF&P paid $30,000 to one provider whose claim requested total reimbursement of $13,000. This occurred because two procedures were entered at $38,940 instead of the actual amount of $3,894. Staff indicated keying errors had been a problem in the past and the fiscal intermediary had subsequently implemented quality review procedures. However, HCF&P did not adequately monitor the activities of the fiscal intermediary including a review of claims entered manually.

Payments From Other Liable Parties Not Always Recovered

HCF&P paid claims for services on recipients who were covered by Medicare. This resulted in thousands of dollars not being properly recovered or paid needlessly because Medicare should have covered a majority of the costs. Payments were not recovered because HCF&P did not have adequate controls in place to identify and monitor certain recipients. Furthermore, payments were made needlessly because the

claims payment system allowed the submission of incorrect forms and an inappropriate edit was permitted.

Certain recipients are covered by insurers other than Medicaid. In many instances this other insurer is Medicare. Recipients covered by both Medicaid and Medicare are known as dual-eligible recipients. For persons enrolled in both programs, any services that are covered by Medicare are paid for by the Medicare program before any payments are made by the Medicaid program. Medicaid is always the "payer of last resort." Requiring Medicare payment is significant because Medicare pays 80% of covered services. Therefore, Medicaid payments are greatly reduced for recipients who are dual-eligible.

Our review of ESRD claims found that dual-eligible recipients enrolled into Medicare retroactively were not always identified as dual-eligible by HCF&P. As a result, claims paid by HCF&P for periods when the recipient was covered by Medicare were not reprocessed to recover overpayment. For 2 of the 50 ESRD recipients we reviewed, HCF&P received confirmation of Medicare coverage after the claims were paid. In both instances, however, Medicare coverage was established retroactively for a period prior to the claim service date. For example, Medicare eligibility data was entered in May of 2006 for Medicare coverage that began in August 2005. The claim in our sample was paid in January 2006 for services rendered in December 2005. HCF&P never identified the claims paid during the time period where the recipient was covered by Medicare. Had HCF&P established controls to identify the two recipients in our sample and required providers bill Medicare, it could have recovered about $90,000.

In addition, providers did not bill on HCF&P's proper form and an edit in the system allowed claims to pay on dual-eligible recipients without prior Medicare payments. Providers are required to submit claims on specified forms for dual-eligible recipients. These forms detail the amount covered by Medicare and the remaining portion of fees to be paid. Further, the claims payment system is not supposed to allow payment for dual-eligible recipients unless requested on this form. However, the claims payment system allowed payment for services on improper forms which resulted in Medicaid paying 100% for services rendered instead of the 20% co-payment amount. Contributing to this problem was an edit in the system that was designed to bypass the

requirement Medicare be billed first. Specifically, this edit allowed certain procedures to be paid by Medicaid even though the services were covered by Medicare. Both of these errors resulted in Medicaid becoming the only payer of claims when it should have been liable for the Medicare co-payment of 20%.

HCF&P officials were unaware these errors allowed Medicaid to be the only payer for dual-eligible recipients until we brought it to their attention. As a result, HCF&P requested a contractor identify and pursue collection of claims for dual-eligible recipients paid by Medicaid without corresponding Medicare payments. HCF&P's contract states the contractor shall be paid 12% of any recoveries made. Yet, many of the claims paid because of form and edit errors, were also overpaid by HCF&P due to payment methods and other problems noted earlier in our report. As a result, HCF&P will pay more in fees to the contractor than the 20% co-payments it would have paid if proper controls had existed. For example, we reviewed four claims for one recipient in our sample where HCF&P paid the claims without proper Medicare processing. After our discussion with HCF&P, regarding this problem, the contractor required the provider bill Medicare for these services. Exhibit 7 shows the result of reprocessing these four claims. In addition, the exhibit shows the amount due the contractor because these claims were overpaid by HCF&P due to rate and unit errors.

Exhibit 7

Example of Recovery Fees Owed Because of Processing and Payment Errors

Claim Number	Amount Billed	Amount Allowed By Medicare	HCF&P's 20% Co-pay	Amount Previously Paid	Overpayment	12% Recovery Fee
1	$ 55,032	$ 1,229	$ 246	$ 46,777	$ 46,531	$ 5,584
2	155,860	2,744	549	132,481	131,932	15,832
3	323,266	5,687	1,137	274,776	273,639	32,836
4	207,814	4,471	894	176,642	175,748	21,090
Total	**$741,972**	**$14,131**	**$2,826**	**$630,676**	**$627,850**	**$75,342**

Source: HCF&P's claims payment system records.

In September 2007, HCF&P provided information indicating it had initiated recovery of $6.6 million.

Ensuring primary payment is obtained from other insurers is necessary to contain costs in the Medicaid program. HCF&P can significantly reduce payments for recipients who are covered by other programs. Therefore, sufficient controls are necessary to ensure dual-eligible recipients are identified and related medical services covered by those programs. Furthermore, controls should ensure that Medicaid pays only that portion of the claim it is liable for.

Overrides Not Always Proper

Overrides to processed claims were not always proper. During our review of claims exceeding $50,000, we found several claims that processed with improper overrides, resulting in inaccurate payments of about $98,000. Additional monitoring and review of these claims by HCF&P can help assure that claims needing overrides to process will be correct.

While most claims process through the claims payment system without manual intervention, certain claims require manual review in order to pay. Claims needing manual intervention are reviewed by fiscal intermediary staff to determine whether the claim should proceed with processing. In certain instances, staff may change payment information related to the claim and continue with processing. However, changes to claims processing were not always proper and resulted in inaccurate payments. Specifically, 3 of the 14 claims that processed with overrides resulted in inaccurate payments totaling about $98,000 to providers. For example, one claim for services performed at a hospital outside of Nevada was overridden to pay at the in-state hospital rate instead of the rate HCF&P contracted to pay the hospital. The claims payment system originally calculated the payment at the correct amount, but when the claim was overridden, the incorrect payment rate was applied. This error resulted in an underpayment to the hospital of about $82,000.

While HCF&P does not perform the override process, it did not monitor the activities of the fiscal intermediary to ensure override processes were working as intended and claims were being paid accurately. Additional controls can ensure HCF&P directives and policies are adhered to when overrides are used to process claims.

Compliance Unit Can Improve Oversight Function

The Compliance Unit, responsible for detecting fraud, abuse and over-utilization in the Medicaid program, can improve its oversight. In fiscal year 2006 total medical expenditures exceeded $1.1 billion. However, the Compliance Unit recovered less than $1.7 million in inappropriate medical costs for the year. Insufficient recoveries resulted from inadequate monitoring of claim activity, a lack of policies and procedures, and staffing problems. Other states' programs can provide valuable information, including best practices that can be applied in Nevada to strengthen its program.

Compliance Unit Recoveries Minimal

Federal regulations require each state to have a statewide program of control of the utilization of all Medicaid services. These programs must safeguard against the unnecessary or inappropriate use of Medicaid services and against excess payments; assess the quality of services; and provide for control of the utilization of all services including inpatient services. However, HCF&P's Compliance Unit, which is responsible for these activities, did not adequately identify overpayments occurring in its program for fiscal year 2006. Based on a review of recoveries that occurred during this time, HCF&P recovered less than ½ of 1% of medical costs for the year. While specific estimates of fraud, abuse, and over-utilization in Medicaid programs is hard to determine, it is generally considered to be more than 1%. California Medicaid program officials estimated fraud to be over 3% in fiscal year 2005 with total payment errors equaling about 8.4% of their annual payments.

HCF&P did not identify and recover overpayments because it did not have sufficient procedures to aid and direct staff in conducting reviews and analysis of medical costs. By analyzing medical costs recorded from fiscal years 2002 to 2006, we identified areas where cost increases were significant. Further review of one of these areas showed significant overpayments had occurred for several years. Procedures such as this, done on a routine or periodic basis can help identify problems before millions of dollars are needlessly paid to providers. In addition to inadequate review and analysis, staff did not fully understand reports designed to assist in identifying fraudulent or abusive activities. Using available information can increase efficiency and staff

resources because reviews can be targeted to specific areas and providers, increasing the likelihood fraud, abuse, and over-utilization will be identified.

Other States Perform Many Procedures

HCF&P can adopt procedures used in other states to strengthen its program. Several states perform routine procedures to identify fraud, abuse, and over-utilization. Some procedures identified included provider audits, random claims review, data mining, using reports that show spikes in provider activity, scoring providers based on claims activity, and comparing provider activity to peers which is referred to as a provider report card. State officials we spoke to indicated that activities related to fraud, abuse, and over-utilization detection and recovery usually pay for themselves. The states we surveyed recovered at least $2.5 for each $1 spent on these activities with one state recovering $6 dollars for every spent dollar. While each state Medicaid program differs, HCF&P can contact other states and determine which practices may be best for Nevada. By doing so, HCF&P can enhance the identification and recovery of misspent funds.

Compliance Unit Staffing Problematic

HCF&P indicated that the Compliance Unit has not performed routine and periodic reviews of claims data because staffing has been problematic since the claims payment system came online in October 2003. We reviewed the occupancy of the three positions responsible for these activities and found vacancies have contributed to the lack of productivity. As of January 2007, each of these positions was vacant for close to a year or more during this time period. However, HCF&P requested additional staffing for this area during the 2007 legislative session and received seven new positions. As a result, discovery and subsequent recovery of fraud, abuse, and over-utilization should increase in the future.

Recommendations

1. Establish controls to routinely monitor and review claims for compliance with stated policies.
2. Consider establishing rates for procedure codes paid by methods other than fixed rates.

3. Establish controls to ensure unlisted procedure codes are not over-utilized and claims are reasonable.
4. Establish and review unit edits for drugs administered by physicians and outpatient facilities as necessary.
5. Enforce policies and procedures to help ensure outpatient hospitals and ESRD facilities bill on a monthly basis.
6. Establish maximum pay edits and periodically review large claims.
7. Establish controls, including written policies and procedures, to monitor and approve rate changes prior to entry in the claims payment system.
8. Strengthen controls to identify and correct keying errors.
9. Develop procedures to identify Medicaid recipients having retroactive enrollment in Medicare and recover appropriate claims.
10. Establish controls over Medicare covered recipients to ensure providers bill Medicare first and submit subsequent claims on the proper HCF&P claim form.
11. Develop internal policies and procedures to ensure edits placed in the claims payment system are proper and appropriate prior to implementation.
12. Monitor significant activities performed by the fiscal intermediary including a periodic review of claims paid through the override process.
13. Develop internal policies and procedures for critical SURS Unit activities.
14. Review SURS fraud reports and determine how they may assist staff in activities.

Additional Oversight Needed for Certain Managed Care Enrollees

HCF&P did not have adequate controls in place to ensure newborns were properly enrolled in managed care. As a result, HCF&P paid for medical services that should have been covered by managed care organizations. HCF&P estimates more than $4 million was paid for medical services on infants who should have been enrolled in managed care. While many factors affected whether newborns were enrolled in managed care properly, HCF&P did not have adequate controls to ensure managed care enrollment was proper and timely. Furthermore, additional controls over other managed care functions can provide assurance unnecessary payments do not occur in the future.

Insufficient Enrollment Controls Led to Inappropriate Payments

Payments for medical services were paid for newborns who should have been enrolled and covered by managed care organizations. Based on reports generated by HCF&P these payments amounted to about $4.4 million. Furthermore, the managed care organization contracts state monthly coverage payments are due for the month of birth and subsequent months the child is program eligible and enrolled with the managed care organization. As a result, HCF&P could be liable for as much as $2.6 million in additional payments for these newborn recipients. This occurred because HCF&P's claims payment system failed to enroll newborns properly and HCF&P did not have an effective compensating process in place to monitor, review, and change this information in the system as necessary.

HCF&P policies require certain recipients residing in urban Clark and Washoe counties be enrolled in managed care. Managed care organizations receive a set payment each month known as a capitation payment. In return, managed care organizations pay for typical medical expenses incurred on enrolled individuals. Generally, newborns of mothers enrolled in managed care are also considered to be enrolled at the date of birth. However, the claims payment system did not always reflect the proper medical plan the infant was enrolled in. This occurred because the claims payment system did not properly enroll the infant in managed care and then defaulted these recipients to fee-for-service coverage. Fee-for-service coverage means claims

are submitted to HCF&P's fiscal intermediary for services rendered and are paid at the standard rates set by HCF&P.

Our review of newborns indicated that nearly two-thirds were not properly enrolled in managed care for the birth month. Specifically, 47 of 72 recipients were not enrolled. Several problems prevented HCF&P from properly enrolling these newborns in managed care. First, the claims payment system enrolled these children in managed care based on their estimated date of birth. However, numerous newborns were born prior to the estimated date of birth. When this happened, the claims payment system was not capable of enrolling the child in managed care back to the birth month. Therefore, these recipients defaulted to fee-for-service coverage. Nearly half of the recipients we reviewed were not properly enrolled in managed care for the birth month because of this problem. Second, newborns were not enrolled because the system placed them in the fee-for-service program when Medicaid eligibility was established. However, the infant's mother was enrolled in managed care prior to birth. As a result, the infant was considered to be enrolled in managed care and a capitation payment was due for the birth month. Third, birth month eligibility was not always established in a timely fashion, or sometimes not at all, by the Division of Welfare and Supportive Services. In a few instances, eligibility was established for the infant's birth month several months afterward. The claims payment system does not automatically enroll an infant in managed care if a significant time period has lapsed from the birth month. Finally, in certain instances, we could not determine why recipients were not enrolled in managed care. Many of these infants were born during earlier phases of the claims payment system implementation when several programs were not functioning as intended. This occurred in about 20% of the recipients we reviewed that were not properly enrolled.

While the claims payment system did not always automatically enroll recipients in managed care properly, HCF&P did not have sufficient controls in place to monitor, review, and modify newborns coverage program. Because of this, HCF&P paid medical claims on a majority of the infants who were not properly enrolled in managed care. Specifically, fee-for-service claims were inappropriately paid on about 85% of the newborn recipients we reviewed that were not properly enrolled. For these infants, 440

claims totaling over $330,000 were paid by HCF&P even though these costs should have been paid by the managed care organizations. HCF&P knew the claims payment system was not enrolling recipients into managed care properly. As a result, it requested a special report and program be designed to identify these recipients. This report, covering the period from January 2004 to May 2006, identified about $4.4 million in fee-for-service payments had been made for recipients who should have been enrolled in managed care.

Capitation Payments Will Also Be Paid

Additionally, HCF&P may be liable for capitation payments to the managed care organizations for many of these recipients. The contracts with the managed care organizations state, “For Medicaid newborns, the Vendor (managed care organization) shall receive a capitation payment for the month of birth and for all subsequent months the child remains program eligible and enrolled with the Vendor.” Furthermore, HCF&P policies state, “All Title XIX Medicaid eligible newborns born to enrolled recipients are enrolled effective the date of birth.” Because newborns were not properly enrolled in managed care, capitation payments were not made. However, HCF&P may be liable for these payments. Reports generated by HCF&P in 2006 indicate as much as $2.6 million in capitation payments may also be due to managed care organizations.

Steps Taken to Correct Problem

HCF&P has taken several steps to alleviate the problems with newborn managed care enrollment. Several program changes have been requested in an attempt to get the claims payment system to automatically enroll as many newborns as possible for the proper time periods. However, manual monitoring and review of infants is necessary to ensure recipients are properly enrolled and that changes to the claims payment system function as intended. Additionally, circumstances may occur that are not programmed into the claims payment system resulting in enrollment in an improper coverage program. Therefore, additional controls, outside the claims payment system, will be necessary to eliminate fee-for-service payments for infants that should be enrolled in managed care.

Further Controls Can Help Ensure Payments Are Proper

HCF&P can develop additional processes to ensure payments related to managed care enrollees are proper. Additional controls needed include reviewing for duplicate payments made to providers by HCF&P and managed care organizations, requiring prior authorizations for medical services to include a review of managed care eligibility, and developing policies and procedures for manual capitation payments. Without these controls, unnecessary and improper payments may continue.

Policies and Procedures Needed Over Duplicate Payments

HCF&P has made the determination through policy that newborns are enrolled in managed care at the date of birth if the child's mother is also enrolled. Therefore, managed care organizations consider these newborns to be enrolled with them from the time of birth. As a result, these organizations have paid for newborns' medical claims submitted by providers. However, policies and procedures had not been established to help ensure providers did not bill HCF&P and the managed care organization for the same services.

HCF&P receives electronic data originating from the managed care organizations regarding services delivered to enrolled recipients. This data, referred to as an encounter claim, reflects information similar to actual claims paid through the fee-for-service program. However, HCF&P did not begin to receive encounter claim information until fiscal year 2007. As a result, encounter claim data remains incomplete. However, during our review of managed care enrollment errors, we found some encounter claim data in the system that could be compared to fee-for-service claims to determine if duplicate billings may have occurred by providers.

In certain instances, providers billed HCF&P and the managed care organization for the same services. We found four newborn recipients in our sample where providers billed HCF&P and the managed care organization for the same service. This equates to about 10% of the newborns from our sample who had fee-for-service payments. In addition, HCF&P recovered about $16,000 in duplicate payments on one recipient because the managed care organization had paid for these services. However, because HCF&P did not have complete encounter data, there could be substantially more than the four recipients we found. HCF&P personnel indicated that they have not

searched for duplicate payments on improperly enrolled newborns because encounter claim data is not complete; however, complete data should be available in late calendar year 2007. Yet, HCF&P does not have policies dictating how this process should be performed. Policies and procedures regarding the identification and recovery of duplicate payments is essential to ensuring providers are not paid more than they are entitled to.

Changes to Prior Authorizations Can Reduce Significant Payments

HCF&P can eliminate large dollar fee-for-service claims from being paid when recipients should be enrolled in managed care. Prior authorizations for payment of hospital services exceeding a certain threshold are necessary for the claim to proceed with payment. These authorizations are reviewed and approved by HCF&P's fiscal agent; however, processes did not include a search to see if newborns should have been covered by managed care organizations. Had this process existed, payments totaling several hundred thousand dollars would have been avoided.

During our review, we found authorizations for payments from the fee-for-service program were provided for recipients who should have been enrolled and covered by managed care. Eight claims totaling about $275,000 were paid because authorization for payment was given to providers. These eight claims accounted for about 81% of the total fee-for-service payments made on all of the recipients tested. Each of these claims was submitted for newborn recipients who should have been enrolled and medical costs covered by managed care. Even though the claims payment system showed them as being enrolled in the fee-for-service program, a review of certain information contained in the claims payment system would have shown they should have been covered by managed care. However, the prior authorization process did not include a review of this information. Therefore, authorizations were given to providers. HCF&P can eliminate these claims from being paid through the fee-for-service program by requiring prior authorizations for infants include a review to ensure the child should not be covered by managed care.

Procedures for Manually Prepared Capitation Payments Needed

Manual capitation payments for recipients of managed care were not always consistent. Therefore, payments or non-payments may not always be proper. Procedures detailing when payments are necessary should ensure their propriety.

Generally, capitation payments are done automatically by the claims payments system on a monthly basis. However, when newborns are not enrolled in managed care properly, automatic capitation payments may not always occur. When this happened, HCF&P prepared manual payments to managed care organizations; yet, payments were not always prepared consistently. Our review of newborns showed manual payments were prepared for some months children were enrolled in managed care, but not others. For instance, a newborn was enrolled in managed care in late May 2004 back to the birth month of April. Due to the timing of enrollment, capitation payments for April, May, and June were not prepared automatically by the claims payment system. HCF&P prepared manual capitations for April and May but did not include June. Because HCF&P does not have policies regarding manual capitation payments, we could not determine if this was appropriate. Procedures should include the circumstances under which payments will and will not be made. This ensures staff prepare payments consistently and that management's directives are carried out.

Recommendations

15. Establish controls to monitor and review the claims payment system's enrollment of managed care newborns to avoid fee-for-service payments.
16. Review encounter claim data for duplicate payments when additional data is received.
17. Require a review to determine whether managed care should be covering charges when prior authorizations are necessary for services provided to newborns.
18. Develop internal policies and procedures to help ensure retroactive capitation payments are properly processed.

Appendices

Appendix A

Audit Methodology

To gain an understanding of the Division of Health Care Financing and Policy, we interviewed management and staff, reviewed applicable laws, regulations, and policies and procedures significant to HCF&P. We also reviewed legislative and executive budgets, legislative committee minutes, Interim Finance Committee minutes and publications of HCF&P. In addition, we identified significant control structures relevant to HCF&P and reviewed controls over these areas. Our review included the general control environment and programmatic areas.

To determine if HCF&P had sufficient procedures to identify fraud, abuse, and over-utilization to ensure control over medical payments, we requested HCF&P provide reports regarding claim activity for fiscal year 2006 for the following medical categories: claims over $50,000, end stage renal disease, hospice, and certain drugs paid based on provider billings. We requested further reports from HCF&P regarding claims paid for Epoetin Alfa for fiscal years 2004, 2005, and 2006. We also requested hospital claims paid under certain procedure codes for service dates prior to March 2004. All reports received from HCF&P regarding claim activity were validated for accuracy as necessary.

We selected 200 claims for testing from the areas noted above by using random or judgmental sampling methods. Judgmental samples included the largest 25 claims from end stage renal disease, hospice, and certain drugs paid based on provider billings. We reviewed claims for reasonableness based on our knowledge of the claims payment system, and compliance with HCF&P policies.

To obtain an effect of control weaknesses noted in our testing, we calculated the amount paid by HCF&P for each drug unit. We compared those amounts to Medicare rates paid during the same time period. Further, we compared Medicare rates to those published in the rate book specified in HCF&P policy. The effect was calculated using

rates paid by Medicare because the rates stated in the book required by HCF&P policy were from 2003.

We also determined the total recoveries of the Compliance Unit by reviewing reports and information from HCF&P and the Medicaid Fraud Control Unit. Then we compared a sample of 10 providers excluded from providing services to the Federal Government against HCF&P records to ensure HCF&P was not paying these providers for services. Further, we discussed the policies and procedures of the Compliance Unit with appropriate personnel. To identify effective practices that could be used to strengthen the Compliance Unit's oversight procedures, we contacted Medicaid officials in California, Texas, Connecticut, and Illinois. We also asked each official to provide an estimate of the amount of fraud, abuse, and over-utilization in their programs and the amount of annual recoveries.

We discussed all issues noted on claims and other errors found during our audit with the appropriate personnel and HCF&P management. Finally, we discussed certain information regarding procedures paid as a percentage of the provider billed amount with the Medicaid Fraud Control Unit. Pursuant to their request, we provided certain information compiled during our audit to them.

To determine if controls existed to ensure fee-for-service payments for certain managed care enrollees were appropriate, we requested a report detailing infants who were not properly enrolled in managed care from HCF&P. We performed procedures to validate the report for accuracy and completeness.

We selected 90 test items to determine why infants were not properly enrolled in managed care. First, we selected 30 infants from the report provided by HCF&P. Fifteen of the infants were selected judgmentally with several recipients having large fee-for-service claim payments. The remaining 15 were selected randomly. Another 30 test items, based on payments made to managed care organizations for infants, were randomly selected from HCF&P files. Finally, we randomly selected 30 recipients from HCF&P reports which showed changes to birth dates made in the claims payment system.

For these 90 recipients, we reviewed information in the claims payment system including birth date, the month and year enrolled in managed care, whether the mother

was enrolled in managed care at birth, fee-for-service claims paid on the infant, and if the managed care organization received bills from providers. We analyzed the information gathered and determined if there was a gap between the date of birth and the month enrolled in managed care. If the infant was supposed to be enrolled in managed care at birth and was not, we determined the reason why the infant was not enrolled. We combined our results and discussed them with HCF&P personnel and management.

Our audit work was conducted from July 2006 to September 2007, in accordance with generally accepted government auditing standards.

In accordance with NRS 218.821, we furnished a copy of our preliminary report to the Director of the Department of Health and Human Services and the Administrator of the Division of Health Care Financing and Policy. On January 9, 2008, we met with agency officials to discuss the results of the audit and requested a written response to the preliminary report. That response is contained in Appendix C, which begins on page 41.

Contributors to this report included:

Shannon Ryan, CPA
Deputy Legislative Auditor

Michael O. Spell, CPA
Audit Supervisor

Stephen M. Wood, CPA
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Appendix B

Medicaid Medical Costs by Category - Fiscal Years 2006 and 2007

Medical Category	Fiscal Year 2006	Fiscal Year 2007
Outpatient Surgery - Hospital Based	$ 2,379,080	$ 1,976,761
Hospital – Inpatient	273,370,663	287,007,984
Hospital – Outpatient	42,420,207	35,410,598
Psychiatric – Inpatient	6,640,947	6,386,597
Mental Health – Outpatient	7,972,191	22,735,008
Intermediate Care Facilities - Mentally Retarded - Public & Private	25,344,819	22,669,618
Special Clinics	3,743,276	4,257,902
Nursing Facilities	147,652,664	154,221,580
Physician	84,090,534	85,383,843
Dentist	14,871,313	14,065,790
Hearing Aid Dispenser	277,715	342,494
Certified Nurse Practitioner	1,017,070	1,012,074
Optometrist	2,277,048	2,403,392
Psychologist	1,538,536	1,498,152
Radiology	1,721,554	1,520,231
Pharmacy	113,262,728	82,751,640
Home Health Agency	2,180,461	3,127,858
Personal Care Aid	53,616,154	64,940,507
Healthy Kids Screening	2,767,154	2,878,849
Ambulance - Air & Ground	5,022,564	5,697,560
Durable Medical Equipment - Disposables – Prosthetics	12,819,874	19,691,058
Therapy	3,795,715	4,874,151
Non-Emergency Transportation	5,428,712	8,263,391
Home and Community Based Waiver - Mentally Retarded	45,255,719	64,377,962
Adult Day Health Center	1,035,622	1,619,268
Optician	468,734	456,272
Laboratory	4,326,025	1,109,360
End Stage Renal Disease Facility	17,236,619	23,104,445
Ambulatory Surgical Centers	2,591,379	3,070,600
Indian Health Services - Tribal – all	3,598,470	3,964,763
Senior Waiver	5,664,990	4,800,790
Targeted Case Management	27,665,122	25,773,438
Transitional Rehab Center – Outpatient	769,794	475,862
Rehabilitation – Inpatient	10,170,229	15,012,510
Adult Group Care Waiver	3,345,458	3,700,216
Physically Disabled Waiver	2,829,166	2,905,659
School Based Care	3,106,808	7,908,489
Mental Health Rehabilitative Services	18,409,809	20,347,293
Health Maintenance Organization	168,689,640	163,921,503
Residential Treatment Centers	16,062,356	21,203,070
Hospice	2,259,189	1,580,900
Hospice Long Term Care	9,934,542	7,662,543
Nurse Anesthetist	552,344	638,464
Critical Access Hospital – Inpatient	1,496,774	2,097,156
Physicians Assistant	879,484	908,951
Mental Health Rehabilitative Services	6,400,165	11,189,526
Other	670,110	816,190
Totals	**$ 1,167,629,527**	**$ 1,221,762,268**

Source: Division of Health Care Financing and Policy Medicaid and Nevada Check Up Fact Book, January 2007, and HCF&P records.

Appendix C

Response From the Division of Health Care Financing and Policy

JIM GIBBONS
Governor

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
1100 E. William Street, Suite 101
Carson City, Nevada 89701
(775) 684-3600

MICHAEL J. WILLDEN
Director

CHARLES DUARTE
Administrator

January 22, 2008

Paul Townsend, CPA, CIA
Legislative Counsel Bureau
401 South Carson Street
Carson City, NV 89701

Re: Legislative Counsel Bureau Audit Findings January 2008

Dear Mr. Townsend:

The Division of Health Care Financing and Policy (DHCFP) has reviewed the audit recommendations from the audit of the DHCFP which were formally reviewed with your staff on January 9, 2008. The DHCFP is in agreement with all recommendations and has included our planned corrective actions in this response.

I want to express my appreciation to you and your staff for completing a well balanced review of our operations and for allowing us the opportunity to identify areas of concern to focus your review. The audit resulted in recommendations that I believe will add efficiency and effectiveness to the administration of the DHCFP and provide equitable reporting for all concerned parties.

I also want to put into perspective the magnitude of the amount of overpayments identified in the report. As identified in your Exhibit 2, DHCFP paid $1,202,523,991 in medical costs during State Fiscal Year 2006. In total, your staff identified approximately $24 million in overpayments made in State Fiscal Year 2006. This equates to approximately 2% of our overall medical costs.

Recommendation 1 **Establish controls to routinely monitor and review claims for compliance with stated policies**

Response *DHCFP agrees that we must review claims regularly to ensure compliance with stated policies. In February 2007, the DHCFP Compliance Unit developed a Financial and Policy Compliance Audit Program Procedure Manual and implemented a process to review a number of claims for each provider type (65 different provider types) at a minimum of once every 24 months. To date, Payment Error Rate Measurement (PERM) audit staff have reviewed and issued internal Financial and Policy Compliance Audit Reports*

for seventeen (17) provider types. As a result of these reviews, a number of system issues have been identified and corrected.

The purpose of these audits is to review the Medicaid Management Information System (MMIS) fee-for-service claims payments, managed care capitation and other payments to substantiate the fiscal integrity of the programs administered by DHCFP and provide regular meaningful information to DHCFP management about the effectiveness of the MMIS, program policy and program operations. After each provider type review is completed, a draft report is provided to the Chief responsible for the particular program service. The draft report outlines the review findings, provides recommendations for corrective action and requests a response to the draft report. The Chief's response to the draft report is included in a final report which is provided to the DHCFP's Administrator, Deputy Administrator, Administrative Services Officer IV, and the Chief responsible for the particular program service. The Compliance Unit is in the process of setting up a tracking system to help ensure actions are taken to correct policy or system issues identified through the Financial and Policy Compliance Audits.

The Surveillance Utilization Review Services (SURS) Unit also regularly reviews various claim types including surgery claims billed with multiple procedures and claims paid at a percentage of billed charges to ensure they are processing correctly and that the providers are billing in accordance with policy.

In addition to the audits conducted by DHCFP Compliance Unit staff, Medicaid and State Children's Health Insurance Program (SCHIP) will be undergoing federal review in Federal Fiscal Year 2008, as part of the PERM program mandated by the Centers for Medicare and Medicaid Services (CMS) (Public Law 107-300). PERM audits consist of a comprehensive review of the DHCFP claims adjudication process and a thorough review of the medical records to determine if payments were made in accordance with DHCFP policy and were medically necessary. Claims from most provider types will be randomly selected for review during this process. A statewide error rate will be calculated for both the Medicaid and SCHIP programs and the DHCFP must submit a corrective action plan to CMS to address all payment errors (overpayments or underpayments) found as a result of the PERM audit.

Recommendation 2 **Consider establishing rates for procedures paid by methods other than fixed rates**

Response *The Rates Unit will issue a Procedure Memo which will identify both*

the procedures and milestones for establishing reimbursement rates, to the extent feasible, for codes which currently pay a percentage of billed charges.

Recommendation 3 **Establish controls to ensure unlisted procedure codes are not over-utilized and claims are reasonable**

Response *The issue of using unlisted codes has been resolved with the implementation of the National Drug Code (NDC) project. The NDC project was implemented for claims that are received by the MMIS on or after January 1, 2008. This will allow the state to code and price based upon the drug's unique NDC identifier. Prior to the implementation of NDC coding, it was appropriate for certain unclassified drug codes to be utilized since there were not enough Health Care Procedure Coding System (HCPCS) codes to account for all of the drugs delivered in an outpatient setting.*

The NDC project was initiated to comply with the federal Deficit Reduction Act of 2005. The NDC is an eleven digit code that details the type of drug, the manufacturer of the drug and the strength of the drug. Collection of NDC codes instead of HCPCS code provides the state the opportunity to specifically price and edit each individual drug. Since the NDC is specific to each drug, this eliminates the use of unlisted procedure codes.

Recommendation 4 **Establish and review unit edits for drugs administered by physicians and outpatient facilities as necessary**

Response *DHCFP has modified the MMIS to not allow units to exceed what is recommended under the Medicare Coverage Policies for Epoetin and Procrit.*

Although unit caps do not exist for all drugs under the Medicare program, DHCFP will create utilization caps for certain high dollar and high utilization drugs.

Recommendation 5 **Enforce policies and procedures to help ensure outpatient hospitals and ESRD facilities bill on a monthly basis**

Response *Medicaid is in the process of changing the billing form to be consistent with Medicare and other insurance companies. This form change is scheduled for early 2008. Prior to implementing this form change, the DHCFP will develop and conduct targeted provider billing training. This training will specifically include End Stage Renal Disease (ESRD) facilities.*

Upon further research by our staff, we have determined that two of the claims identified in your report were in fact correctly billed on a daily basis, because the recipients were hospitalized during the month which caused a break in consecutive outpatient ESRD related services.

Recommendation 6 **Establish maximum pay edits and periodically review large claims**

Response *There are currently three edits in MMIS that pertain to maximum pay thresholds. However, these edits are informational only and do not affect disposition of the claim. They are used to generate reports in the DHCFP Decision Support System (DSS) for analysis.*

The edits currently identify: inpatient hospital payments are over $500,000; outpatient claims that exceed $10,000; and claims where the calculated allowed amount is greater than or less than a set percentage of billed charges. An additional edit has been added to determine if providers are over or under billing for their services.

The DHCFP will institute a process in the SURS Unit to run the informational reports mentioned above on a monthly basis and investigate, and when appropriate, recover excess payments.

Recommendation 7 **Establish controls, including written policies and procedures, to monitor and approve rate changes prior to entry in the claims payment system**

Response *The DHCFP Rates Unit has established a written policy addressing the review of rates once uploaded into the MMIS. Review of rates prior to adjudication of any claims will help ensure that incorrect payments described above do not occur.*

Recommendation 8 **Strengthen controls to identify and correct keying errors**

Response *The Quality Assurance (QA) and Compliance Department at First Health Services Corporation (FHSC) has established a quality assurance process to facilitate monitoring the receipt, deposit and posting of cash. In addition, DHCFP's Budget and Accounting Unit has established a cash receipt audit process.*

The current QA process to monitor for keying errors is described below.

- *All claims go through the verification queue*
- *Data Entry Supervisor performs audits based on the following parameters:*
  - *100% for all new hires during the first ninety (90) days of hire.*
  - *Random sampling is conducted on all other data entry employees based on the data entry staff performance level.*
  - *QA department has implemented audit procedures for Data Entry.*

To address the errors identified in the report FHSC will create a Quality Management process for the data entry area. This will start with establishing a data entry report. This report will show the results of the QA process, and will include a set of reports showing volume and detected error rates. Using this report, DIICFP and FIISC will establish target error percentage and will jointly monitor the error rates and identify the best way to adjust the process to meet that targeted percentage.

Recommendation 9 **Develop procedures to identify Medicaid recipients having retroactive enrollment in Medicare and recover appropriate claims**

Response *DHCFP will create reports for audit purposes on claims that meet the conditions of retroactive Third Party Liability (TPL) coverage along with an audit process to review contracted TPL vendor activities.*

DHCFP's TPL vendor, Health Management Services, Inc. (HMS), bills for services incurred during the time period that retro-active Medicare is identified. As this procedure is currently in place, DHCFP staff will develop and implement a quality assurance review of the process.

Your report correctly noted that two claims had not been recovered at the time the report was issued. However, upon further analysis, it has been determined that the claims identified in the audit have since been recovered.

Recommendation 10 **Establish controls over Medicare covered recipients to ensure providers bill Medicare first and submit subsequent claims on proper HCF&P claim form**

Response *The MMIS system edit was updated and no longer bypasses the Medicare payment requirement for the codes identified during*

the audit. The by-pass criterion edit was based on the CMS form and is accurate for professional services billed on the form, but not for ESRD facilities which currently bill Medicare on the Universal Billing (UB) form. Staff is in the process of changing the requirement that ESRD facilities bill on the CMS form rather than the UB form. By requiring ESRD facilities to utilize the CMS form, DHCFP will be able to pay claims appropriately using facility guidelines for recipients eligible for both Medicare and Medicaid.

Recommendation 11 **Develop policies and procedures to ensure edits placed in the claims payment system are proper and appropriate prior to implementation**

Response *The current system will be improved by creating internal Policy and Procedures for the Change Management (CM) process. Procedures will be created to strengthen the checks and balances used to verify edits are proper and appropriate prior to production release.*

Recommendation 12 **Monitor significant activities performed by the fiscal intermediary including a periodic review of claims paid through the override process**

Response *Policy changes, system issues and special circumstances require the agency have the ability to override claims. The current override process was established prior to the audit but not prior to the inappropriate claim payment identified in the report.*

To strengthen this process, an additional check has been implemented and a weekly report has been created to identify all claims processed as an override. Additionally, a QA process will be developed to review these claims in order to identify weaknesses and ensure appropriate use of the override capability.

Recommendation 13 **Develop internal policies and procedures for critical SURS Unit activities**

Response *The SURS Unit will develop written internal policies and procedures for critical Unit activities.*

Recommendation 14 **Review fraud reports and determine how they may assist staff in activities**

Response *The SURS Unit will develop written internal policies and procedures to review fraud reports quarterly and take action on those identified as outliers.*

Recommendation 15 **Establish controls to monitor and review the claims payment system's enrollment of managed care newborns to avoid fee-for-service payments**

Response *DHCFP was aware of this problem. This issue was caused by problems within DHCFP's MMIS and the Division of Welfare and Supportive Services (DWSS) NOMADS eligibility system. DHCFP has been working with DWSS since 2005 to correct these problems and will continue working with them on these issues.*
Work orders are in place to correct all computer system issues identified in this audit. Upon completion of these work orders it is anticipated that approximately 98% of all newborns will be enrolled in managed care correctly.

Recommendation 16 **Review encounter claim data for duplicate payments when additional data is received**

Response *Timely enrollment of newborns will eliminate the opportunity for duplicate billing. This will be substantially addressed upon completion of computer work orders described in the response to Recommendation 15. Additionally, the Division's actuary, Milliman Inc., will prepare a report which will help identify duplicate billing and provide DHCFP with sufficient information to recover incorrect payments.*

Recommendation 17 **Require a review to determine whether managed care should be covering charges when prior authorizations are necessary for services provided to newborns**

Response *DHCFP will issue a procedure memo to FHSC instructing them to first check the mother's HMO enrollment before issuing any prior authorization for cases where the recipient (newborn) should be enrolled in Managed Care.*

Recommendation 18 **Develop internal policies and procedures to help ensure retroactive capitation payments are properly processed**

Response *The Business Lines Unit has developed a written internal policy to ensure retroactive capitation payments are properly processed.*

Again, I would like to thank the Legislative Counsel Bureau audit staff for their professionalism and dedication in providing a valuable service to the Division.

If you have additional questions please contact me at 775-684-3600.

Sincerely,

Charles Duarte
Administrator

Cc: Michael J. Willden, Director, Department of Health and Human Services
Michael Torvinen, Deputy Director, Department of Health and Human Services
Diane Comeaux, ASO IV, DHCFP
Mary Wherry, Deputy Administrator, DHCFP
John Liveratti, Chief of Compliance, DHCFP

Division of Health Care Financing and Policy
Response to Audit Recommendations

Recommendation Number		Accepted	Rejected
1	Establish controls to routinely monitor and review claims for compliance with stated policies.....	X	
2	Consider establishing rates for procedure codes paid by methods other than fixed rates.	X	
3	Establish controls to ensure unlisted procedure codes are not over-utilized and claims are reasonable.	X	
4	Establish and review unit edits for drugs administered by physicians and outpatient facilities as necessary	X	
5	Enforce policies and procedures to help ensure outpatient hospitals and ESRD facilities bill on a monthly basis	X	
6	Establish maximum pay edits and periodically review large claims	X	
7	Establish controls, including written policies and procedures, to monitor and approve rate changes prior to entry in the claims payment system.....	X	
8	Strengthen controls to identify and correct keying errors .	X	
9	Develop procedures to identify Medicaid recipients having retroactive enrollment in Medicare and recover appropriate claims.....	X	
10	Establish controls over Medicare covered recipients to ensure providers bill Medicare first and submit subsequent claims on the proper HCF&P claim form ..	X	
11	Develop internal policies and procedures to ensure edits placed in the claims payment system are proper and appropriate prior to implementation	X	
12	Monitor significant activities performed by the fiscal intermediary including a periodic review of claims paid through the override process.....	X	
13	Develop internal policies and procedures for critical SURS Unit activities	X	

Division of Health Care Financing and Policy
Response to Audit Recommendations
(continued)

Recommendation Number		Accepted	Rejected
14	Review SURS fraud reports and determine how they may assist staff in activities.....	X	
15	Establish controls to monitor and review the claims payment system's enrollment of managed care newborns to avoid fee-for-service payments	X	
16	Review encounter claim data for duplicate payments when additional data is received.....	X	
17	Require a review to determine whether managed care should be covering charges when prior authorizations are necessary for services provided to newborns.....	X	
18	Develop internal policies and procedures to help ensure retroactive capitation payments are properly processed.....	X	
	TOTALS	18	0