LA24-12

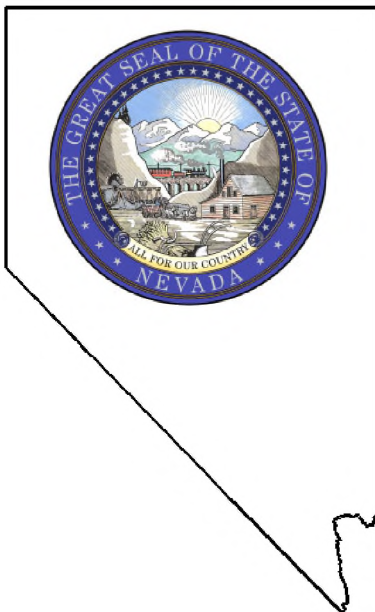
STATE OF NEVADA

Performance Audit

Department of Health and Human Services
Division of Health Care Financing and Policy

Hospice Care Claims and Fiscal Agent Contract

2023



Legislative Auditor
Carson City, Nevada

Audit Highlights

Highlights of performance audit report on the Division of Health Care Financing and Policy, Hospice Care Claims and Fiscal Agent Contract issued on September 10, 2024.

Legislative Auditor report # LA24-12.

Background

The mission of the Division of Health Care Financing and Policy (Division) is to: 1) purchase and provide quality health care services to low-income Nevadans in the most efficient manner; 2) promote equal access to health care at an affordable cost to the taxpayers of Nevada; 3) restrain the growth of health care costs; and 4) review Medicaid and other state health care programs to maximize potential federal revenue. The Division administers both Nevada Medicaid and Check Up programs.

The hospice services program is designed to provide support and comfort for Medicaid eligible recipients who have a terminal illness and are expected to live 6 months or less and have decided to receive end-of-life care.

The Medicaid Management Information System (MMIS) is a computerized claims processing and information retrieval system the Nevada Medicaid program must have to be eligible for federal funding. The MMIS is managed by a contractor known as a fiscal agent.

In fiscal year 2023, the Division was primarily funded with federal grants totaling $4.5 billion and state appropriations of about $1.2 billion. As of November 3, 2023, the Division had 338 positions authorized, of which 261 positions were filled (23% vacancy rate). The Division has offices located in Carson City, Elko, Las Vegas, and Reno.

Purpose of Audit

The purpose of the audit was to determine if the Division of Health Care Financing and Policy has adequate controls over hospice care to limit improper provider payments and if the solicitation and oversight of the current fiscal agent contracts complied with applicable laws, policies, contract terms, and best practices.

Audit Recommendations

This audit report contains 10 recommendations to reduce improper hospice care payments and improve the fiscal agent contracting process.

The Division accepted the 10 recommendations.

Recommendation Status

The Division's 60-day plan for corrective action is due on December 9, 2024. In addition, the 6-month report on the status of audit recommendations is due on June 9, 2025.

Hospice Care Claims and Fiscal Agent Contract

Division of Health Care Financing and Policy

Summary

The Division lacks adequate controls to ensure hospice care provider payments comply with federal and state Medicaid policies. Specifically, we found hospice providers billed and received payment for duplicate services for room and board charges. Additionally, providers billed and received payment for higher home care rates than allowed and did not properly bill the service intensity add-on rate. Furthermore, the Division paid claims with service dates after a recipient's date of death. We estimate over $386,000 in improper payments for hospice claims paid during calendar years 2020 – 2022. These improper payments occurred because the Division's MMIS lacks critical system controls regarding these services, and the Division has not developed additional compensating controls. Without proper controls, improper hospice payments will continue.

After performing an analysis of overpayments by providers and service type, we observed no significant patterns. Therefore, we were unable to determine if the overpayments were provider errors or possible fraud.

Better oversight and contracting practices for fiscal agent services will help ensure state contracting laws and policies are followed. The Division's current fiscal agent contract has been in effect since January 2011, over 12 years, and the Division has frequently modified the scope of work, amount, and duration of the fiscal agent contract over its administration of the MMIS. The initial contract maximum was $176 million and is currently at $803 million (354% increase). By not regularly soliciting competitive bids for fiscal agent services, other vendors are denied the opportunity to compete and offer different solutions and pricing.

Key Findings

The Division overpaid hospice providers who improperly billed for duplicate room and board services. Hospice care providers improperly billed and were paid for 115 duplicate dates of services during calendar years 2020 – 2022. These overpayments occurred because the MMIS did not have the proper system controls in place to prevent hospice providers from billing and receiving payment for duplicate room and board services. We conservatively estimate over $155,000 in improper payments for hospice claims were paid during this period. (page 7)

The Division overpaid hospice providers who improperly billed for the higher routine home care rate. For 13 of 20 recipients randomly selected and tested, we found hospice providers used the higher routine rate for more than the recipient's initial 60 days in hospice care. We conservatively estimate about $114,000 was improperly paid to providers during the 3-year period. (page 9)

The Division overpaid hospice providers who improperly billed the service intensity add-on rate. We found providers improperly charged for the service intensity add-on for 668 (38%) out of the 1,755 service intensity add-on dates paid. For 376 (56%) dates of services, the recipient had no death date based on Division of Public and Behavioral Health, Office of Vital Records data. The remaining 292 (44%) dates of services improperly paid were found to have dates of death, but providers billed the service intensity add-on before the recipient's last 7 days of life. We also found hospice providers were paid beyond the daily limits established for the service intensity add-on. We estimate over $117,000 in improper payments were made during calendar years 2020 – 2022. (page 10)

The Division overpaid hospice providers who improperly billed for services claimed to be rendered after a recipient's date of death. We identified four dates of services where providers received payment for services claimed to be rendered after the recipient's date of death during calendar years 2020 – 2022. For fee-for-service claims, proper controls are not in place to retroactively identify improper payment of services dated after a recipient's date of death. While the amount of improper payments for hospice services were immaterial, the potential effect could be significant for all fee-for-service claims. (page 12)

The Division's current fiscal agent contract has been in effect since January 2011 but frequent modifications to the scope of work, amount, and contract duration have occurred. By not regularly soliciting competitive bids for fiscal agent services, interested vendors are denied the opportunity to compete and offer different solutions and pricing. (page 15)

STATE OF NEVADA

LEGISLATIVE COUNSEL BUREAU

CARSON CITY OFFICE
LEGISLATIVE BUILDING
401 S. CARSON STREET
CARSON CITY, NEVADA 89701
(775) 684-6800

LAS VEGAS OFFICE
GRANT SAWYER STATE OFFICE BUILDING
555 E. WASHINGTON AVENUE, SUITE 4400
LAS VEGAS, NEVADA 89101
(702) 486-2800

Legislative Commission
Legislative Building
Carson City, Nevada

This report contains the findings, conclusions, and recommendations from our performance audit of the Department of Health and Human Services, Division of Health Care Financing and Policy, Hospice Care Claims and Fiscal Agent Contract. This audit was conducted pursuant to 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.

This report includes 10 recommendations to reduce improper hospice care payments and improve the fiscal agent contracting process. We are available to discuss these recommendations or any other items in the report with any legislative committees, individual legislators, or other state officials.

Respectfully submitted,

Daniel L. Crossman, CPA
Legislative Auditor

April 24, 2024
Carson City, Nevada

Hospice Care Claims and Fiscal Agent Contract

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Introduction

Background

The mission of the Division of Health Care Financing and Policy (Division) is to: 1) purchase and provide quality health care services to low-income Nevadans in the most efficient manner; 2) promote equal access to health care at an affordable cost to the taxpayers of Nevada; 3) restrain the growth of health care costs; and 4) review Medicaid and other state health care programs to maximize potential federal revenue. The Division works in partnership with the federal government's Centers for Medicare and Medicaid Services (CMS) to assist in providing quality medical care for eligible individuals and families.

The Division administers both Nevada Medicaid and the Children's Health Insurance Program (CHIP). Medicaid provides health care coverage for many people, including low-income families with children whose family income is at or below 133% of the federal poverty level; Supplemental Security Income recipients; certain Medicare beneficiaries; and recipients of adoption assistance, foster care, and some children aging out of foster care. Nevada Check Up is the State's CHIP program which provides health care benefits to uninsured children from low-income families who are not eligible for Medicaid, but whose family income is at or below 200% of the federal poverty level.

Approximately 75% of the State's Medicaid population receive medical and dental benefits through a managed care organization. However, rural enrollees and certain excluded Medicaid covered services, such as hospice care, are covered under the fee-for-service program within Nevada Medicaid. The fee-for-service program pays providers directly for covered services received by eligible Medicaid beneficiaries.

Total Nevada Medicaid enrollment during the month of October 2023 was 907,824 Medicaid and 30,259 CHIP, for a total of 938,083 recipients.

Hospice Care

The hospice program is designed to provide support and comfort for Medicaid eligible recipients who have a terminal illness, are expected to live 6 months or less, and have decided to receive end-of-life care. Covered hospice services address the needs of the individual, their caregivers, and their families while maintaining quality of life as a primary focus. This care is provided in the recipient's place of residence, which could be a specialized hospice facility, skilled nursing facility, intermediate care facility, or in his or her own home.

Hospice providers bill Nevada Medicaid for room and board reimbursement when a recipient is living in a long-term care facility, such as a skilled nursing facility. Providers are then reimbursed at 95% of the room and board cost charged by the long-term care facility, less any amount a recipient in a facility can contribute to the cost of their own care.

Hospice services are billed separately, and the base rates are determined by the CMS. The CMS allows states to increase the rates above the federal base, such as for different geographic locations. Hospice care services include the following:

- Routine Home Care – The level of care provided when the recipient is not in a crisis and is paid at a daily rate for each day the recipient is in hospice care. This rate is paid without regard to the volume or intensity of services provided on any given day. Medicaid pays a higher rate for the first 60 days of hospice care, then a lower rate starting on day 61.

- Service Intensity Add-On (SIA) – An additional rate paid for the use of social workers or a registered nurse when these services are provided during routine home care in the last 7 days of a recipient's life. The SIA payment is equal to the continuous home care hourly rate, multiplied by the hours of nursing or social work provided, up to a total of 4 hours for each day of service.

- Continuous Home Care – To be used during brief periods of crisis, described as a period in which a recipient requires

continuous care to achieve palliation or management of acute medical symptoms and only as necessary to maintain the terminally ill recipient at home and not in an inpatient facility. The continuous home care rate is divided by 24 hours to arrive at an hourly rate. A minimum of 8 hours per day must be provided, up to a maximum of 24 hours each day.

- Inpatient Respite Care – Short-term inpatient care provided to a recipient in an approved hospice care facility to relieve the family members or other persons caring for the recipient. Up to 5 consecutive days are allowed and any additional days of respite care are made at the routine home care rate.

- General Inpatient Care – To be used for days when a recipient is receiving hospice care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.

See Appendix A on page 18 for the Nevada Medicaid hospice care rates from federal fiscal years 2019 – 2023.

Medicaid Management Information System

The Medicaid Management Information System (MMIS) is a computerized claims processing and information retrieval system the Nevada Medicaid program must have to be eligible for federal funding. The MMIS includes automated claims processing and subsystems that support program integrity activities, such as provider screening; claim processing; utilization reviews; and other functions necessary for the economic and efficient operations, management, monitoring, and administration of the Medicaid program. CMS validates and certifies the State's MMIS. States receive 90% of federal financial participation for the development and design of the system and once certified states may receive 75% federal financial participation for the operation of this system, all other program costs are paid at 50%. The MMIS is implemented, managed, and maintained by a contractor known as a fiscal agent.

Budget and Staffing

In fiscal year 2023, the Division was primarily funded with federal grants totaling $4.5 billion and state appropriations of over $1.2 billion. Exhibit 1 shows the Division's fiscal year 2023 revenues and expenditures.

Division Revenues and Expenditures Fiscal Year 2023 — Exhibit 1

Revenues	Inter-Governmental Transfers[2]	Health Care Financing and Policy Administration	Increase Quality of Nursing Care	Nevada Check Up	Nevada Medicaid	Prescription Drug Rebates	Totals
Beginning Cash	$ 59,899,460	$ 1,208,478	$ 900,000	$ -	$ 482,887	$ -	$ 62,490,825
State Appropriations	-	27,907,183	-	13,464,457	1,180,867,082	-	1,222,238,722
Program Taxes	12,599,660	-	45,075,964	-	-	-	57,675,624
Federal Grants	-	138,077,925	-	34,421,350	4,332,059,498	-	4,504,558,773
Licenses and Fees	-	1,351,261	-	-	-	-	1,351,261
Other Revenues[1]	112,593,580	604,903	105,276	1,243,361	51,017,356	412,396,249	577,960,725
American Rescue Plan Act[3]	-	1,337,130	-	-	12,179,925	-	13,517,055
Interagency Transfers	31,953,243	1,411,273	-	121,473	625,193,138	-	658,679,127
Total Revenues	**$217,045,943**	**$171,898,153**	**$46,081,240**	**$49,250,641**	**$6,201,799,886**	**$412,396,249**	**$7,098,472,112**
Expenditures							
Personnel	$ -	$ 25,320,333	$ -	$ -	$ -	$ -	$ 25,320,333
Operating / Equipment	-	6,971,046	-	-	-	-	6,971,046
Fiscal Agent	-	43,037,767	-	-	-	-	43,037,767
Medical Payments	-	6,827,046	-	43,381,487	5,788,455,233	-	5,838,663,766
Program Costs	-	12,617,743	-	-	62,919,446	-	75,537,189
Information Services	-	841,242	-	-	-	-	841,242
American Rescue Plan Act	-	1,337,130	-	-	12,179,925	-	13,517,055
Interagency Transfers	152,501,141	70,429,442	45,181,240	1,585,374	63,174,324	412,396,249	745,267,770
State Cost Allocations and Assessments	-	958,052	-	-	-	-	958,052
Total Expenditures	**$152,501,141**	**$168,339,801**	**$45,181,240**	**$44,966,861**	**$5,926,728,928**	**$412,396,249**	**$6,750,114,220**
Differences	$ 64,544,802	$ 3,558,352	$ 900,000	$ 4,283,780	$ 275,070,958	$ -	$ 348,357,892
Less: Reversions to General Fund	-	2,317,901	-	4,283,780	274,588,070	-	281,189,751
Balance Forwards to FY 2024	**$ 64,544,802**	**$ 1,240,451**	**$ 900,000**	**$ -**	**$ 482,888**	**$ -**	**$ 67,168,141**

Source: State accounting system.

[1] Other revenues include county and local government reimbursements, fines, interest, and other miscellaneous revenue.

[2] Intergovernmental transfers collect funds from other state and local governmental entities to be used as state matching funds for certain Medicaid expenditures.

[3] Effective March 11, 2021, the American Rescue Plan Act (ARPA) provided federal funding to aid state, local, and tribal governments in their response and recovery efforts resulting from the COVID-19 public health emergency. These funds only include the ARPA funds that were allocated to the Division from the Governor's Finance Office.

As of November 3, 2023, the Division had 338 positions authorized, of which 261 positions were filled (23% vacancy rate). The Division has offices located in Carson City, Elko, Las Vegas, and Reno.

Medicaid Program Audits
This audit is part of an ongoing oversight of the Nevada Medicaid program. Medicaid related audits released by the Legislative Auditor since calendar year 2020 are listed below:

- Dual Enrollments and Supplemental Drug Rebates
  Report # LA24-01, released in January 2023
- Information Security
  Report # LA22-12, released in March 2022
- Delivery of Treatment Services for Children with Autism
  Report # LA22-04, released in January 2021

Including the Hospice Care Claims and Fiscal Agent Contract audit, we have identified over $40 million in improper payments and uncollected funds as of calendar year 2023, with recommendations to improve controls and program monitoring over the Nevada Medicaid program.

Scope and Objectives

The scope of our audit covered the systems and practices in place during calendar years 2020 – 2022 and prior years for fiscal agent contract activities. Our audit objectives were to:

- Determine if the Division of Health Care Financing and Policy has adequate controls over hospice care to limit improper provider payments.
- Determine if the solicitation and oversight of the current fiscal agent contracts complied with applicable laws, policies, contract terms, and best practices.

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 Nevada Revised Statutes 218G.010 to 218G.350. 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.

Lack of Adequate Controls Over Hospice Care Payments

The Division lacks adequate controls to ensure hospice care provider payments comply with federal and state Medicaid policies. Specifically, we found hospice providers billed and received payment for duplicate services for room and board charges. Additionally, providers billed and received payment for higher home care rates than allowed and did not properly bill the service intensity add-on rate. Furthermore, the Division paid claims with service dates after a recipient's date of death. We estimate over $386,000 in improper payments for hospice claims were paid during calendar years 2020 – 2022. These improper payments occurred because the Division's MMIS lacks critical system controls regarding these services, and the Division has not developed additional compensating controls. Without proper controls, improper hospice payments will continue.

After performing an analysis of overpayments by providers and service type, we observed no significant patterns. Therefore, we were unable to determine if the overpayments were provider errors or possible fraud.

Hospice Providers Improperly Paid for Duplicate Room and Board Services

The Division overpaid hospice providers who improperly billed for duplicate hospice room and board services during calendar years 2020 – 2022. We identified and analyzed all 5,509 hospice provider room and board claims made during this period and identified 115 (2%) claims with duplicate dates of services. We conservatively estimate these duplicate payments exceeded $155,000 during this 3-year period.

The duplicate services identified corresponded to hospice provider reimbursement of room and board services while a hospice recipient was in a skilled nursing facility. Exhibit 2 shows examples of duplicate room and board payments.

Examples of Duplicate Room and Board Payments — Exhibit 2

Provider	Recipient	Claim	First Date of Service	Last Date of Service	Number of Days Paid	Amount Paid	Overpayments[2]
A	1	1	1/27/2021	1/31/2021	5	$ -[1]	$ -
		2	1/27/2021	1/31/2021	5	$ 178[1]	$ 178
		3	1/27/2021	1/31/2021	5	$ 121[1]	$ 121
Totals					**15**		**$ 299**
B	2	1	3/1/2020	3/31/2020	31	$3,065	$ -
		2	3/1/2020	3/31/2020	31	$3,696	$3,696
Totals					**62**		**$3,696**
C	3	1	9/1/2022	9/18/2022	18	$2,153	$ -
		2	9/1/2022	9/18/2022	18	$2,153	$2,153
Totals					**36**		**$2,153**
D	4	1	8/1/2020	8/23/2020	23	$1,798[1]	$ -
		2	8/17/2020	8/31/2020	8	$ 972	$ 851
Totals					**31**		**$ 851**

Source: Auditor analysis of Nevada Medicaid calendar years 2020 – 2022 claims data.

[1] The amount paid by the Division is reduced by the amount a recipient in an institution is able to contribute to the cost of their own care.

[2] Overpayments were calculated by including only those claims that were paid in addition to the first paid claim.

These overpayments occurred because the MMIS did not have the proper system controls in place to prevent hospice providers from billing and receiving payment for duplicate room and board services. After we brought these duplicate payments to the attention of the Division, the Division and its fiscal agent performed their own analysis, and confirmed the duplicate payment of room and board services. They found that some system controls from the previous system did not correctly carry forward into the modernization of the MMIS that occurred in 2019.

As defined by the Center of Medicare and Medicaid Services, duplicate claims are any claims paid across more than one claim for the same beneficiary, procedural codes, and service date by the same provider. Duplicate payments for Medicaid services are considered overpayments per federal regulation, which states that an overpayment is the amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for furnished services.

Improper Use of the Higher Routine Home Care Rate

The Division overpaid hospice providers who improperly billed for the higher rate of routine home care services. We conservatively estimate these overpayments to be about $114,000 for claims paid during calendar years 2020 – 2022. The Division overpaid hospice providers because the MMIS did not have the proper system controls in place to prevent hospice providers from receiving payment after billing for the higher routine home care rate beyond a recipient's initial 60 days.

During calendar years 2020 – 2022, we identified 80 (6%), out of 1,388 recipients, whose providers improperly billed and received payment for the higher routine home care rate. These improper billings accounted for 527 dates of services. From the population of 80 recipients, we randomly selected a sample of 20 recipients. We found 13 recipients with 29 dates of services where providers billed the higher routine home care rate for more than the allowable first 60 days of hospice enrollment. Exhibit 3 provides examples of improper use of the higher routine home care rate that was paid to providers and the associated overpayments.

Examples of Improper Use of the Higher Care Rate **Exhibit 3**

Recipient	Total Days Paid at Higher Rate	Total Amount Paid	Excess Number of Days at Higher Rate	Allowed Amount[1]	Overpayments
1	175	$39,302	115	$33,887	$5,415
2	118	25,578	58	22,897	2,681
3	120	26,854	60	24,119	2,735
4	120	25,736	60	24,150	1,586
5	90	$17,167	30	$15,699	$1,468

Source: Auditor analysis of Nevada Medicaid calendar years 2020 – 2022 claims data.

(1) Allowed amount is calculated by using the higher rate for 60 days and then the lower rate for the remaining days of hospice enrollment.

Using statistical principles, we projected that for the population of 80 recipients, with 527 dates of service, about $114,000 in overpayments were made. The excessive use of the higher routine home care rate and resulting overpayments occurred because the Division does not have the proper system controls in the MMIS to prevent hospice providers from being paid for the higher routine home care rate after a recipient's initial 60 days.

Per federal and Nevada Medicaid policy, hospice providers are only allowed to bill and receive payment for the higher routine home care rate during the first 60 days a recipient is enrolled in hospice care, unless there is a 60 day break between their last date of service and reenrollment into hospice care.

Service Intensity Add-On Rate Used Inappropriately

The Division improperly paid some hospice providers claiming the hospice service intensity add-on rate. This rate is to be used in addition to the home care rate and used during the last 7 days of a recipient's life, with a maximum of 4 hours per day. Because the Division's MMIS did not have proper system controls in place, we estimate over $117,000 in improper payments were made to providers for the service intensity add-on rate during calendar years 2020 – 2022.

Overpayments occurred for two reasons. First, the MMIS allowed hospice providers to receive payment for the service intensity add-on rate before the last 7 days of a recipient's life. Second, the MMIS allowed payments beyond the daily limits established for the service intensity add-on rate.

Service Intensity Add-On Rate Used Before Recipient's Last 7 Days of Life

Because of the lack of proper system controls, the Division overpaid hospice providers who improperly billed the service intensity add-on rate before a recipient's last 7 days of life. We found providers improperly charged the service intensity add-on for 668 (38%) of the 1,755 service intensity add-on dates tested. For 376 (56%) of the 668 dates, we found Medicaid recipients were not deceased based on Division of Public and Behavioral Health, Office of Vital Records data. Consequently, the use of the service intensity add-on rate in these cases was inappropriate. The remaining 292 (44%) dates of services improperly paid were made for deceased individuals, but providers billed for the additional rate before the recipient's last 7 days of life. We included in Exhibit 4 examples of the service intensity add-on rate being improperly used.

Examples of Service Intensity Add-On Rate Improperly Used **Exhibit 4**

Provider	Recipient	Date of Death	Number of Service Dates Before Last 7 Days of Life	Overpayments
A	1	N/A[1]	19	$4,222
B	2	N/A[1]	9	1,179
C	3	N/A[1]	16	2,900
D	4	10/31/2022	33	2,488
E	5	09/21/2021	14	$2,250

Source: Auditor analysis of Nevada Medicaid calendar years 2020 – 2022 claims data.

[1] Recipients did not have a date of death during our audit testing. If no date of death, all service intensity add-on payments are considered overpayments.

As shown above, the service intensity add-on rate was billed for more than 7 days and can result in substantial improper payments. Per federal regulation and Nevada Medicaid billing policy, the service intensity add-on rate is only to be used during the last 7 days of a recipient's life.

We received death records data from the Division of Public and Behavioral Health, Office of Vital Records, and used Social Security numbers to match with deceased hospice recipients that had service intensity add-on rate claims. Based on our testing of all service intensity claims that were paid between calendar years 2020 – 2022, we identified about $73,000 in overpayments to providers for those recipients that did not have a reported death date, or when the service intensity add-on rate was billed outside the last 7 days of the recipient's life.

Overpayments to hospice providers occurred because the MMIS does not have proper system controls in place to detect and prevent the improper payment of the service intensity add-on rate. In addition, the Medicaid Service Manual also does not have policies to address the proper use and billing of the service intensity add-on rate. The Medicaid Service Manual is a guide for providers regarding the coverage and limitations of Medicaid services and helps ensure compliance with federal and state laws.

Service Intensity Add-On Rate Daily Limits Were Exceeded

The Division overpaid hospice providers who improperly billed more than the allowed 4 hours per day for the hospice service intensity add-on rate. We estimate the service intensity add-on

rate was improperly paid for between 213 (20%) to 339 (32%) of the 1,048 service intensity dates of services tested. We estimated improper payments beyond the daily limit to be between $44,000 to almost $69,000 for claims paid during calendar years 2020 – 2022. A range was calculated because in addition to the number of hours billed by a provider, the Division allows providers to bill their usual and customary rate, which can be lower than the allowed rate.

These overpayments are in addition to our finding previously discussed regarding providers improperly billing and receiving payment for the service intensity add-on rate before a recipient's last 7 days of life. Per federal billing policy, the service intensity add-on rate is limited to a maximum of 4 hours per day, for a total of 7 days leading up to the recipient's date of death.

While the Division is using the correct hourly rate for the service intensity add-on rate, the MMIS is allowing hospice providers to bill and receive payment for up to 16 hours per day. In addition, the State's Medicaid Service Manual and the hospice care billing guide for provider services do not address the proper number of hours to be billed by providers.

Inadequate Controls Allowed Service Payments for Deceased Recipients

The Division overpaid providers who improperly billed for hospice services claimed to be rendered after a recipient's date of death. Our testing of all paid hospice services for calendar years 2020 – 2022 identified four dates of service where providers received payment for services claimed to be rendered after a recipient's date of death. While the amount associated with these claims were immaterial, we discovered the MMIS does not retroactively identify any fee-for-service claims where providers received payment for services claimed to be rendered after the recipient's date of death. Therefore, the number of improper payments related to dates of services could be significant across all Medicaid fee-for-service claims.

Payments for medical services claimed to have been rendered after a Medicaid recipient's death are considered overpayments per federal regulation, which states that an overpayment is the

amount paid by a state Medicaid agency to a provider which is in excess of the amount that is allowable for furnished services.

For fee-for-service claims, these overpayments occurred because the Division does not have adequate controls over the prevention, detection, and recovery of improper payments for services claimed to be rendered after a recipient's date of death. The Division does have system controls to prevent payment for services with dates after a recipient's date of death if the date of death is already entered in the MMIS. However, the system controls do not retroactively identify improper payment of services dated after a recipient's date of death, but processed before the date of death was entered in the MMIS. Per discussions with Division personnel, it can take up to several months before a date of death is entered for a recipient, thus leaving significant time when a provider can bill and receive payment for services dated after a recipient's date of death.

Recommendations

1. Create MMIS system controls to prevent hospice providers from receiving payment for duplicate hospice room and board services.
2. Analyze hospice provider claims to identify those providers that received overpayments for duplicate hospice room and board services and recoup the overpayments.
3. Create MMIS system controls to prevent providers from receiving payment for the higher hospice routine home care rate if the recipient is continuously enrolled in hospice care for over 60 days.
4. Analyze hospice provider claims to identify those providers that received overpayments for the higher hospice routine home care rate and recoup the overpayments.
5. Create MMIS system controls to prevent improper payment of the service intensity add-on rate.
6. Modify the Medicaid Service Manual for hospice services to include the proper use of the service intensity add-on rate.
7. Modify the MMIS system controls to limit the service intensity add-on amount paid to only 4 hours per day.

8. Develop a process to identify improper payments for services claimed to be rendered after a recipient's date of death and recoup any improper payments identified.

Fiscal Agent Contracting Process Can Be Improved

Better oversight and contracting practices for fiscal agent services will help ensure state contracting laws and policies are followed. The Division's current fiscal agent contract has been in effect since January 2011, over 12 years, and the Division has frequently modified the scope of work, amount, and duration of the fiscal agent contract over its administration of the MMIS. The initial contract maximum was $176 million and is currently at $803 million (354% increase). By not regularly soliciting competitive bids for fiscal agent services, other vendors are denied the opportunity to compete and offer different solutions and pricing.

Significant Contract Modifications Since 2011

The Division has frequently modified the scope of work, amount, and duration of its contract with its MMIS fiscal agent. The fiscal agent is primarily responsible for maintaining the MMIS and processing provider payments. Since the initial execution of the contract in 2011, 26 amendments have followed. While some of the 26 amendments were federally mandated, many were done at the request of the Division or the fiscal agent. Contract amendments were used to change the nature of the vendor's work instead of soliciting competitive bids from interested vendors. Some of the significant contract amendments are listed in Exhibit 5.

Significant Fiscal Agent Contract Amendments **Exhibit 5**

Amendment Number	Scope Changes	Contract End Date	Time Extension (Years)	Change in Contract Maximum
15	Added modernization of the Core MMIS, including personnel for modernization.	1/1/2019	2.5	$ 45,000,000
16	Changed subcontractors providing services and modified formula for fiscal agent fee to process claims.	6/30/2020	1.5	$158,940,788
17	Added MCO expansion and dental benefit administrator, and realigned modernization project work.	6/30/2020	0	$ 4,566,457
18	Modified go live period, integrated policy changes to scope of work, made changes to maintenance and enhancement hours, adjusted warranty period, and added a position.	6/30/2020	0	$ 26,419,368
22	Removed pharmacy services, deleted personal care services, clarified contract language, and added system enhancements and upgrades.	6/20/2023	3	$133,375,761
26	Adjusted various operating expenses based on the Consumer Price Index, and increased hourly cost of system enhancement work.	6/30/2028(1)	5 to 9	$245,353,529

Source: Division fiscal agent contract amendments.

(1) Amendment 26 extends the contract term until June 2028 or June 2032, if the options to use two, 2-year extensions are exercised.

The contract was initially effective from January 2011 – June 2016 for a maximum of $176 million. Four contract extensions have since taken place, amending it through June 2028, with the option for two, 2-year extensions to 2032 if desired. Amendments have altered the contract scope without competitive bids, increasing the contract maximum to more than $803 million. Annual payments to the fiscal agent averaged $46 million between fiscal years 2011 and 2023.

Per the State Administration Manual and state regulation, it is the general policy that bids be solicited at least every 4 years, except in the case of emergency or when it is determined that only one vendor exists that provides the product or services.

To solicit bids, a Request for Proposal (RFP) is generally used which allows the Division to publicly solicit for a commodity or service and requests vendors to submit proposals. Submitted proposals are then competitively judged and scored. This process helps ensure fair competition among vendors and that they are selected based on established criteria and a fair evaluation of

proposals. Because of the use of established criteria, in which cost is only one component, competitively soliciting a vendor does not always mean a new vendor will be selected. Instead, competitive solicitation helps ensure the Division receives the best value for the commodity or service solicited.

The Division has not successfully solicited bids since 2011 for several reasons. First, Division staff indicated they regularly communicate with other states and MMIS contractors to know what is available. Second, the Division believes that if the fiscal agent does not change, this will minimize distractions to providers and members. Finally, the Division has not effectively identified and documented their own needs for MMIS fiscal agent services. The Division took a year to develop the specifications for an RFP released in 2021. Once the RFP specifications were identified, it took the Department of Administration, Purchasing Division, 9 months to draft the RFP. Included in the development of the RFP was the need for review by the Centers for Medicare and Medicaid Services. An RFP was eventually released, but later cancelled by the Purchasing Division due to undisclosed defects in the process.

Without competition through an RFP process, the Division cannot ensure it is receiving the best value for fiscal agent services due to private negotiations taking place, which can be unduly influenced in many ways. In addition, when contract amendments significantly modify the original scope of work, other vendors are denied the opportunity to compete and offer different solutions and pricing, which could lead to additional costs and inferior performance.

Recommendations

9. Work with the Department of Administration, Purchasing Division, to identify, document, and update specifications so an effective RFP can be prepared before the expiration of the current contract in June 2028.
10. Competitively solicit bids for a fiscal agent before the current contract term ends, in compliance with state policies.

Appendix A

Hospice Care Service Rates
Federal Fiscal Years 2019 – 2023

Provider Location	Code	Description	FFY19[1]	FFY20	FFY21	FFY22	FFY23
Carson City	0551	Service Intensity Add On – Last 7 Days	$ 43.69	$ 58.45	$ 59.30	$ 61.69	$ 62.74
	0650	Hospice Service – Routine Home Care – Days 1-60	206.52	195.69	198.15	205.80	209.57
	0651	Hospice Service – Routine Home Care – Days 61+	162.28	154.66	156.62	162.64	165.61
	0652	Hospice Service – Continuous Home Care	10.92	14.61	14.61	15.42	15.69
	0655	Hospice Service – Inpatient Respite Care	192.71	475.59	482.76	503.52	513.39
	0656	Hospice Service – General Inpatient Care	$794.07	$1,025.83	$1,039.03	$1,079.07	$1,100.46
Clark County	0551	Service Intensity Add On – Last 7 Days	$ 48.05	$ 65.86	$ 67.20	$ 68.90	$ 72.32
	0650	Hospice Service – Routine Home Care – Days 1-60	227.14	220.50	224.53	226.95	237.62
	0651	Hospice Service – Routine Home Care – Days 61+	178.48	174.27	177.46	179.36	187.77
	0652	Hospice Service – Continuous Home Care	12.01	16.47	16.80	17.23	18.08
	0655	Hospice Service – Inpatient Respite Care	208.03	523.13	533.31	551.40	576.84
	0656	Hospice Service – General Inpatient Care	$868.17	$1,147.02	$1,167.81	$1,185.84	$1,242.09
Washoe County	0551	Service Intensity Add On – Last 7 Days	$ 40.01	$ 55.01	$ 56.98	$ 58.21	$ 61.03
	0650	Hospice Service – Routine Home Care – Days 1-60	189.14	184.18	190.39	195.59	204.54
	0651	Hospice Service – Routine Home Care – Days 61+	148.63	145.56	150.48	154.58	161.64
	0652	Hospice Service – Continuous Home Care	10.00	13.75	14.24	14.55	15.26
	0655	Hospice Service – Inpatient Respite Care	179.80	453.53	467.89	480.43	502.01
	0656	Hospice Service – General Inpatient Care	$731.62	$969.61	$1,001.15	$1,027.58	$1,075.07

Source: Health Care Financing and Policy Federal Fiscal Years 2019 – 2023 Hospice Care Rates.
[1] Federal Fiscal Year (FFY) is from October 1st – September 30th.

Appendix B
Audit Methodology

To gain an understanding of the Division of Health Care Financing and Policy (Division), we interviewed staff, reviewed state and federal laws, regulations, and policies and procedures significant to the Division's operations. We also reviewed financial information, prior audit reports, budgets, legislative committee minutes, Board of Examiners minutes, and other information describing the Division's activities. Furthermore, we documented and assessed the Division's controls related to Medicaid hospice care claims and fiscal agent contract practices.

Our audit included a review of the Division's internal controls significant to our audit objectives. Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved. Internal control comprises the plans, methods, policies, and procedures used to fulfill the mission, strategic plan, goals, and objectives of the entity. The scope of our work on controls related to Medicaid hospice care claims and fiscal agent contracting included the following:

- Design of information system control activities (Control Activities); and
- Performance of monitoring activities (Monitoring).

Deficiencies and related recommendations to strengthen the Division's internal control systems are discussed in the body of this report. The design, implementation, and ongoing compliance with internal controls is the responsibility of agency management.

To assess the reliability and reasonableness of the claims data received from the Division's fiscal agent, we randomly selected 8 hospice providers from a combined unique list of all 114 hospice

providers downloaded from the Medicaid Management Information System (MMIS). For each of the eight hospice providers, we searched for all paid hospice claims listed under that provider in the MMIS for the first and last months of calendar years 2020 – 2022, for a total of 57 hospice claims identified. We then compared those claims to the list of claims found under each provider in the claims data extracted by the fiscal agent. We then took a randomly selected sample of 16 Medicaid recipients, 8 from each of the 2 hospice provider types, that had paid claims during the first and last months of calendar years 2020 – 2022. We compared the list of hospice claims found in the fiscal agent's claims data to all paid hospice claims listed under each recipient in the MMIS. We determined that data to be reliable for our audit objectives.

To assess the reliability and reasonableness of the Department of Health and Human Services, Division of Public and Behavioral Health, Office of Vital Records data received, we randomly selected 5 deceased individuals from each calendar year 2019 – 2022, for a total of 20 deceased individuals. Using the Social Security number of each individual selected, we then observed Office of Vital Records' staff search in their electronic database by each Social Security number, and confirmed the information of the deceased individual in the electronic database matched the data we received. We then entered two different judgmentally selected dates for each calendar year into the Office of Vital Records' electronic database for a total of eight dates. Using the dates selected, we judgmentally selected one individual listed under each date entered and compared the eight individuals' information from the Office of Vital Records' electronic database to the information listed in the provided death records data. We determined the data to be reliable for our audit objectives.

To determine if the Division improperly paid hospice providers for duplicate room and board services, we first identified a total of 5,509 room and board claims, including zero balance claims, paid for calendar years 2020 – 2022, from the MMIS extracted claims data. We included paid zero balance claims in our testing to identify those duplicate claims where a provider's claim balance was reduced to zero, either due to recipient cost sharing, or the

claim was paid due to other third party liability. We included these claims because the provider billed on a separate claim for the same recipient and dates of services, which were also paid by the Division. We then summarized and analyzed the claims data by dates of services and Medicaid recipient identification number to identify 258 claims with overlapping and duplicate dates of services. We reviewed all 258 claims and calculated improper payments by only counting one of the duplicates or overlapping claims that were paid at a later date. If the paid date was the same for each claim, we then counted the claim that had a lower paid amount, if applicable. If one of the claims was a paid zero balance claim, we counted the other claim as the duplicate claim. For any claims where dates of services did not overlap completely, we prorated the improper payments by taking the claim total paid amount and dividing it by the number of days that actually overlapped with the other claim's dates of services.

To determine if providers improperly used the higher home care rate beyond the initial 60 days, we extracted all paid dates of services that used the higher revenue rate during calendar years 2020 – 2022. Then we summarized the data by Medicaid recipient identification number and the number of units of the higher rate paid. Next we filtered the data to determine which Medicaid recipient identification number had more than 60 units paid at the higher rate. In total, we identified 80 Medicaid recipients with more than 60 units paid at the higher rate to their respective hospice providers. After identifying the recipients with more than 60 units paid at the higher rate, we randomly selected 20 Medicaid recipient identification numbers and tested each recipient to determine if the recipient had a 60 day gap between services. If a 60 day gap between the higher home care rate was identified, we did not count those payments as exceptions. We calculated improper payments by calculating the difference between the higher rate used and the lower rate that should have been used. To calculate our estimate of improper payments of the higher home care rate in calendar years 2020 – 2022 to the population, we used professional judgement and statistical principles to extrapolate the amount. The amount was

extrapolated at a 90% confidence level, resulting in a level of precision of plus or minus $33,300 (29%).

To determine if the Division overpaid hospice providers who improperly billed the service intensity add-on before the last 7 days of a recipient's life, we analyzed claims data and identified a total of 1,755 paid services intensity add-on dates during calendar years 2020 – 2022. Using recipients' Social Security numbers, we matched claims data to the Office of Vital Records data and identified 376 dates of services where recipients were not deceased. In addition, we identified 292 service intensity add-on dates of services where the recipient was deceased, but the service intensity add-on was used before the last 7 days of a recipient's end of life. Improper payments were calculated by adding all amounts for dates of services paid that were not eligible.

To determine if the correct daily units and rates were paid for the service intensity add-on, we reviewed what the MMIS allowed for the number of daily units and rates, and extracted MMIS paid claims data with the service intensity add-on during calendar years 2020 – 2022. We then calculated improper payments based on a range, since the MMIS was set up to allow 16 units per day instead of 4 units at an hourly rate. We tested to see if the total per unit for each claim was more or less than the daily 4 hour total. If the per unit total was more than 4 hours, we subtracted from the allowed daily maximum rate. We also calculated the total daily rate that should have been allowed. Next, we calculated improper payments if the total amount paid was also higher than the allowed daily rate. If the amount paid was higher than the allowed daily rate, we subtracted the allowed amount from the amount paid to get the total improper payment. Improper payments calculations were done only for those claims that billed for more than the allowed 4 hours per day or the maximum daily rate.

To determine if hospice services were paid after a recipient's date of death, we used the MMIS extracted claims data and identified a total of 18,928 hospice dates of services that were paid during calendar years 2020 – 2022. Using recipient Social Security

numbers, we matched the claims data to the Office of Vital Records data. We then tested for any dates of services rendered that were greater than a recipient's date of death. Improper payments were calculated based on the amount paid for each service date after a recipient's date of death.

To assess the solicitation and oversight of fiscal agent contracts used by the Division and ensure that they complied with applicable laws, policies, contract terms, and best practices, we obtained and reviewed the original MMIS Takeover Request for Proposal (RFP) issued by the Division in February 2010, and the contract that was awarded in January 2011. We reviewed the applicable laws, policies, and contract terms. We also reviewed RFP scoresheets obtained from the Department of Administration, Purchasing Division. Next, we also discussed with the Division how they monitor the fiscal agent's performance. In addition, we reviewed the Divisions' contract administration plan and contract ownership timeline.

To document the history of contract modifications, we created a timeline based on the original contract and the amendments that were adopted, for a total of 26 amendments. We reviewed each of the 26 amendments were properly approved by the Division, the Purchasing Division, and the Board of Examiners, when appropriate. We reviewed and summarized changes to the scope of work. To calculate the payments made to the fiscal agent, we obtained financial data from the state accounting system.

In documenting the Division's recent process to contract for its fiscal agent services, we reviewed the cancelled 2021 RFP provided to us by the Purchasing Division. We also researched what other states are using as their fiscal agents by searching the Medicaid federal government website that listed current fiscal agents used in other states.

We used nonstatistical audit sampling for our audit work, which was the most appropriate and cost-effective method for concluding on our audit objectives. Based on our professional judgment and review of authoritative sampling guidance, we believe that nonstatistical sampling provided sufficient and

appropriate audit evidence to support the conclusions in our report. Although we used nonstatistical audit sampling, the results of our random sample regarding the use of the higher home care rate allowed us to use statistical principles to project the results to the population.

Our audit work was conducted from June 2022 through August 2023. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In accordance with Nevada Revised Statutes 218G.230, we furnished a copy of our preliminary report to the Administrator of the Division of Health Care Financing and Policy. On April 1, 2024, 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 25.

Contributors to this report included:

William F. Evenden, MS
Deputy Legislative Auditor

Ray Sanchez, MBA, CCM
Deputy Legislative Auditor

Todd C. Peterson, MPA
Chief Deputy Legislative Auditor

Appendix C

Response From the Division of Health Care Financing and Policy

Joe Lombardo
Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH CARE FINANCING AND POLICY

Helping people. It's who we are and what we do.

Stacie Weeks, JD MPH
Administrator

April 22, 2024

Daniel L. Crossman, CPA
Legislative Auditor
Legislative Counsel Bureau
401 S. Carson St.
Carson City, NV 89701

Dear Mr. Crossman:

In response to the letter and draft audit report provided by the Legislative Counsel Bureau (LCB) dated March 22, 2024, the Nevada Division of Health Care Financing and Policy (DHCFP) provides this written response to the 10 recommendations as follows:

1. Create MMIS system controls to prevent hospice providers from receiving payment for duplicate hospice room and board services.

   Response: The Division agrees with this recommendation and has implemented this modification. An MMIS system change was implemented on January 30, 2023, to audit for exact and possible duplicate hospice room and board services.

2. Analyze hospice provider claims to identify those providers that received overpayments for duplicate hospice room and board services and recoup the overpayments.

   Response: The Division agrees with this recommendation and has completed this analysis. Claims identified as duplicates have been processed back to February 1, 2019. The amount of the recoupment from providers was $313,429.19.

3. Create MMIS system controls to prevent providers from receiving payment for the higher hospice routine home care rate if the recipient is continuously enrolled in hospice care for over 60 days.

   Response: The Division agrees with this recommendation and has implemented this modification as stated. It was implemented in the MMIS on May 15, 2023.

4. Analyze hospice provider claims to identify those providers that received overpayments for the higher hospice routine home care rate and recoup the overpayments.

1100 E. William Street, Suite 101 ● Carson City, Nevada 89701
775-684-3676 ● Fax 775-687-3893 ● dhcfp.nv.gov

Response: The Division agrees with this recommendation. Analysis of claims for those providers who received overpayment at the higher hospice routine home care rate was completed. Claims identified as overpayments were processed back to February 1, 2019. The amount of the recoupment was $814,655.46.

5. Create MMIS system controls to prevent improper payment of the service intensity add-on rate.

   Response: The Division agrees with this recommendation. On average, it can take up to 100 days for the date of death to be entered into the MMIS. Often the provider has submitted their claim prior to the entry of the date of death into MMIS. The Division will work with the Division of Welfare and Supportive Services who conducts this process to implement new efficiencies through automation to shorten the length of time for entering the date of death into the system. The Division will also implement MMIS controls to prevent improper payment of the service intensity add-on rate accordingly.

6. Modify the Medicaid Service Manual for hospice services to include the proper use of the service intensity add-on rate.

   Response: The Division agrees with this recommendation and plans to modify Medicaid Services Manual (MSM) Chapter 3200 to add requirements regarding the service intensity add-on category for hospice services. The new policy language will include the duration and scope of who may render hospice services per federal requirements.

7. Modify the MMIS system controls to limit the service intensity add-on amount paid to only 4 hours per day.

   Response: The Division agrees that a service intensity add-on should be utilized as described. Therefore, the Division has an audit in place within its MMIS system to limit the service to a maximum of four hours a day and has verified that this audit is functioning properly.

8. Develop a process to identify improper payments for services claimed to be rendered after a recipient's date of death and recoup any improper payments identified.

   Response: The Division agrees with this recommendation. See answer #5 above. In addition, we will develop a process to identify improper payments, and recoup those identified in accordance with state and federal law.

9. Work with the Department of Administration, Purchasing Division, to identify, document, and update specifications so an effective RFP can be prepared before the expiration of the current contract in June 2028.

   Response: The Division agrees with the recommendation to continue to work with the Purchasing Division and follow state policies for purchasing and procurement for vendor services. In working with the Purchasing Division, the Division will take the necessary actions to prepare for an effective RFP if the Purchasing Division believes it is necessary to ensure that the contract for these services is in the best interests of the state.

10. Competitively solicit bids for a fiscal agent before the current contract term ends, in compliance with state policies.

    Response: See answer to #9 above.

Should you have any questions or require additional information, you may contact Russ Steele at (775) 830-3627.

Sincerely,

Stacie Weeks
Administrator

Division of Health Care Financing and Policy's Response to Audit Recommendations

	Recommendations	Accepted	Rejected
1.	Create MMIS system controls to prevent hospice providers from receiving payment for duplicate hospice room and board services	X	
2.	Analyze hospice provider claims to identify those providers that received overpayments for duplicate hospice room and board services and recoup the overpayments	X	
3.	Create MMIS system controls to prevent providers from receiving payment for the higher hospice routine home care rate if the recipient is continuously enrolled in hospice care for over 60 days	X	
4.	Analyze hospice provider claims to identify those providers that received overpayments for the higher hospice routine home care rate and recoup the overpayments	X	
5.	Create MMIS system controls to prevent improper payment of the service intensity add-on rate	X	
6.	Modify the Medicaid Service Manual for hospice services to include the proper use of the service intensity add-on rate	X	
7.	Modify the MMIS system controls to limit the service intensity add-on amount paid to only 4 hours per day	X	
8.	Develop a process to identify improper payments for services claimed to be rendered after a recipient's date of death and recoup any improper payments identified	X	
9.	Work with the Department of Administration, Purchasing Division to identify, document, and update specifications so an effective RFP can be prepared before the expiration of the current contract in June 2028	X	
10.	Competitively solicit bids for a fiscal agent before the current contract term ends, in compliance with state policies	X	
	TOTALS	10	