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We have completed an audit of the Division of Mental Health and Developmental Services (MHDS). 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 Mental Health and Developmental Services for their assistance during the audit.

Respectfully presented,

Paul V. Townsend, CPA
Legislative Auditor

April 24, 2006
Carson City, Nevada

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL SERVICES

AUDIT REPORT

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EXECUTIVE SUMMARY

DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL SERVICES

Background

The Division of Mental Health and Developmental Services (MHDS) is responsible for the development, administration, coordination, and evaluation of state treatment and training programs for persons with mental illness or developmental disabilities. This audit focused on the Division's developmental services, which are provided by three regional centers.

The regional centers provide a full range of services, including service coordination, family support, jobs and day training, and residential support. In fiscal year 2005, the Division spent approximately $88.3 million to provide these services, with an average monthly caseload of almost 3,900 persons. Most of the people receiving services are covered by Medicaid. The Federal Government pays a little over half of the costs of services covered by Medicaid.

Purpose

This audit focused on procedures used at the Division's developmental services agencies to establish billing rates and eligibility for federal programs, and the new automated billing system developed in-house and piloted at Sierra Regional Center (SRC) during fiscal year 2005. The purpose of our audit was to determine whether the agencies maximized federal reimbursements for the cost of providing developmental services.

Results in Brief

The Division can obtain additional federal funds by improving its rate-setting and billing procedures for

developmental services. Specifically, the Division could have collected about $1.2 million in additional federal funds if case management services had been billed at actual cost for the past two fiscal years. At least half of this amount can be collected if the Division re-bills Medicaid promptly. In addition, the new billing system piloted at Sierra Regional Center (SRC) was effective since it billed Medicaid for almost all billable services. However, system modifications can increase SRC's collection of federal funds by more than $200,000 annually. Timely implementation is critical since the Division is in the process of implementing the new system at the other two regional centers. These two regional centers account for over 75 percent of the total clients served statewide. Finally, the Division can collect additional funds by ensuring it bills Medicaid for all eligible clients.

Principal Findings

- The Division can collect additional federal funds by ensuring targeted case management (TCM) services are charged at actual cost. Although the regional centers charged $91 per hour, we determined the actual cost was a little over $103 per hour. Based on this variance, we estimate the Division could have collected additional federal funds totaling approximately $564,000 for fiscal year 2004 and $623,000 for fiscal year 2005. Until recently, the Division did not have the information needed to establish the actual cost. According to State Medicaid representatives, the Division can collect additional funds if it acts promptly since there is a 2-year limit on re-billing. Therefore, by re-billing Medicaid promptly, the Division can collect the additional federal funds for services provided in fiscal year 2005 and part of fiscal year 2004. (page 10)
- We noted errors on cost reports prepared by the Division to obtain reimbursement from Medicaid for services provided at their ICF/MR (Intermediate Care

Facility for the Mentally Retarded) facilities. The reports overstated reimbursable costs in fiscal year 2004 by about $1.6 million at SRC and $230,000 at Desert Regional Center (DRC). Since Medicaid had not finalized its review and settlement of the reports at the time of the audit, the Division revised the reports and re-submitted them. Since these reports affect fees charged by the regional centers, additional controls are needed to ensure they are accurate. (page 12)

- A new billing system for developmental services piloted at SRC was effective. Our analysis indicates Medicaid was billed for almost 98 percent of the total amount that should have been billed for the first 10 months of fiscal year 2005. However, since SRC billed Medicaid about $16 million for this period, minor billing errors can have a significant impact on revenue. As a result, we determined SRC did not bill services totaling about $430,000. We identified two main reasons why these services did not get billed – data reliability problems and misunderstandings of Medicaid rules. The Division has already fixed some problems and is working on others. If these services had been billed, SRC would have received about $235,000 in additional federal funds. This is the federal portion of the $430,000 that was not billed to Medicaid. (page 14)

- The Division did not have sufficient documentation for its new billing system. In addition, the design, programming, and system administration was for the most part done by one person. These control weaknesses increase the risk of error or loss of state funds. Since the regional centers receive a considerable amount of federal funds from billing Medicaid, agency operations could be negatively impacted if these control weaknesses are not addressed. (page 15)

- DRC can increase the amount of federal funds received from Medicaid by revising its billing procedures when clients are eligible for more than

one federal program. In fiscal year 2005, DRC billed two federal block grant programs about $114,000 for services to clients that were Medicaid eligible. Because the amounts reimbursable under the block grant programs are capped, but Medicaid is not, these programs should only be billed for expenses not reimbursable by Medicaid. Furthermore, services totaling $50,000 that were provided to some of these Medicaid clients after DRC received its allotment from the block grants, were not billed to Medicaid. In total, billing Medicaid for these services would have resulted in DRC receiving about $90,000 in additional federal funds in fiscal year 2005. (page 16)

- Although a significant percentage of clients were Medicaid eligible, additional controls will help ensure Medicaid eligibility is pursued for all clients. Control weaknesses included a lack of written procedures and supervisory oversight of service coordinators' efforts in this area. Since over half of the cost of Medicaid services is reimbursed by federal funds, pursuing eligibility reduces the amount of state funds needed to provide developmental services. Strong controls are critical because the cost of providing services to clients can be from several hundred to several thousand dollars per month. (page 17)

Recommendations

This audit contains 11 recommendations to improve the Division's billing process for developmental services so that federal reimbursements are maximized. Three recommendations relate to establishing fees for case management services based on the actual cost. In addition, we made five recommendations to help ensure the new billing system for developmental services bills for all eligible services. Finally, we made three recommendations to help ensure the Division bills Medicaid for all eligible clients. (page 26)

Agency Response

The Agency, in its response to our report, accepted all 11 recommendations. (page 23)

Introduction

Background

The Division of Mental Health and Developmental Services (MHDS) is responsible for the development, administration, coordination, and evaluation of state treatment and training programs for persons with mental illness or developmental disabilities. Their services are intended to maximize each individual's independence, functioning, satisfaction, and self-sufficiency while ensuring the exercise of individual rights.

Mental Health and Developmental Services facilities are located throughout Nevada as follows:

- SOUTH (Clark County) – Southern Nevada Adult Mental Health Services (SNAMHS) and Desert Regional Center (DRC)
- NORTH (Washoe County) – Northern Nevada Adult Mental Health Services (NNAMHS) and Sierra Regional Center (SRC)
- RURAL (Balance of State, including Mesquite in Clark County) – Rural Clinics and Rural Regional Center (RRC)
- Statewide Forensic Services – Lake's Crossing Center in Sparks

The Division is funded primarily by state appropriations and federal funds. In fiscal year 2005, the Division had a total of 1,328 authorized positions and expenditures of about $198 million. The focus of this audit was on the Division's developmental services, which are provided by the three regional centers – DRC, SRC, and RRC.

Services Provided by the Regional Centers

The regional centers provide services for people with developmental disabilities and related conditions throughout Nevada. In the Las Vegas area, Desert Regional Center offers community-based services in its main office and three branch offices in Henderson, Pahrump, and North Las Vegas. The largest state-run residential treatment program is located on the DRC campus. In the Reno area, Sierra Regional Center provides community-based services and is the location of the other state-run residential treatment program. Rural Regional Center, located in Carson City with satellite offices

in Elko, Fallon, Silver Springs, and Winnemucca, offers community-based services for the rural Nevada counties.

The regional centers provide a full range of services for people with developmental disabilities and related conditions that include:

- **Service Coordination/Case Management** – All people who are eligible for services from a regional center are assigned a service coordinator (case manager). Service coordinators assist people in obtaining needed benefits and assessments. The customer and service coordinator jointly develop a service plan and the coordinator oversees the quality of services.
- **Family Support Services** – These services assist families to care for relatives with developmental disabilities and related conditions. The goal is to prevent costly residential placement by assisting the family in caring for their relatives in the family home. There are a variety of services, including respite care, in-home training, clinical assessments, and counseling. Families can also receive financial assistance from the Family Preservation Program grants.
- **Jobs and Day Training** – Job services range from pre-vocational and vocational training in supervised settings to supported employment, including activities needed to sustain paid employment. Day training services are designed to provide vocational experiences for people who need more intensive personal or behavioral support.
- **Residential Support** – This includes state-run facilities, called Intermediate Care Facilities for the Mentally Retarded (ICF/MR), providing 24-hour supervision and training to individuals who require intensive support. These homes house from 4 to 12 people and are located at the Desert Regional Center and Sierra Regional Center. Residential services also include supported living arrangements (SLAs), which are individualized living supports contracted through private providers in the community. The Division has been reducing the number of people residing in ICF/MR, and increasing the number residing in SLAs.

Expenditures and Caseloads

In fiscal year 2005, the Division spent approximately $88.3 million to provide developmental services - $53.6 million at DRC, $25.2 million at SRC, and $9.5 million at RRC. Appendix C shows a detailed listing of expenditures for each regional center. The regional centers also had 391 full-time equivalent positions authorized for the year. Average monthly caseloads for fiscal year 2005 for the centers are shown in Exhibit 1 by type of service.

Exhibit 1

Average Monthly Caseloads
Fiscal Year 2005

Service	DRC	SRC	RRC	Total
Service Coordination	2,456	888	545	3,889
Family Support	1,615	357	312	2,284
Jobs and Day Training	1,179	391	233	1,803
Residential Support	876	462	236	1,574

Source: Agency reports on performance indicators.

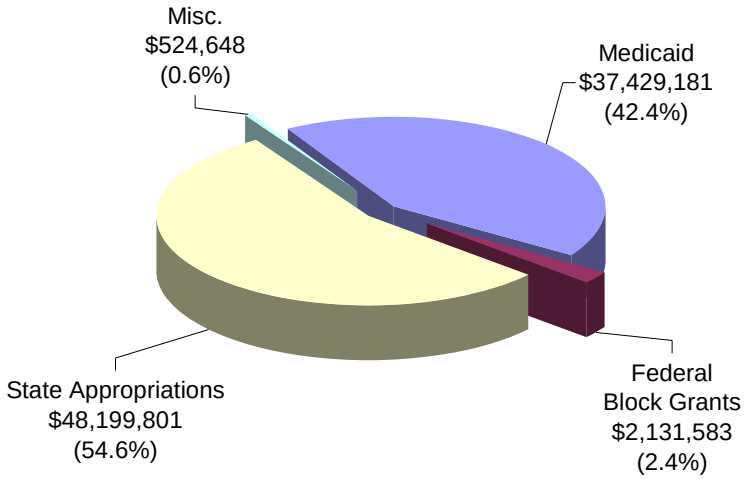
Note: Service Coordination is provided to all clients and represents the total persons served. In addition, many clients receive more than one type of service and therefore are included more than once in these caseloads.

Funding of Developmental Services

Funding for developmental services is primarily from federal funds and state appropriations. The primary federal funding source is Medicaid, but a small portion is also received from two block grants – Title XX and Temporary Assistance for Needy Families (TANF). Exhibit 2 shows the funding sources and combined amounts for DRC, SRC, and RRC for fiscal year 2005.

Exhibit 2

Developmental Services
Funding Sources and Amounts (millions)
Fiscal Year 2005



Source: State accounting records.

Medicaid Funding

The Federal Government pays about half of the costs of the Medicaid Program. Most of the people receiving developmental services from the Division are Medicaid eligible, and most services are covered by Medicaid. When a Medicaid client receives eligible services, a bill is sent to the claims administrator for Medicaid. The Division receives a check for the federal share of the approved Medicaid rate for the service. The state share is funded by state appropriations included in the Division's budget. For all services provided to Medicaid clients in Nevada, the federal share is the same – approximately 55 percent in fiscal year 2005.

Scope and Objective

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 focused on procedures used at the Division's developmental services agencies to establish billing rates and eligibility for federal programs, and the new automated billing system developed in-house and piloted at SRC during fiscal year 2005. The objective of our audit was to determine whether the agencies maximized federal reimbursements for the cost of providing developmental services.

Findings and Recommendations

The Division can obtain additional federal funds by improving its rate-setting and billing procedures for developmental services. Specifically, the Division could have collected about $1.2 million in additional federal funds if case management services had been billed at actual cost for the past two fiscal years. At least half of this amount can be collected if the Division re-bills Medicaid promptly. In addition, the new billing system piloted at Sierra Regional Center (SRC) was effective since it billed Medicaid for almost all billable services. However, system modifications can increase SRC's collection of federal funds by more than $200,000 annually. Timely implementation is critical since the Division is in the process of implementing the new system at the other two regional centers. These two regional centers account for over 75 percent of the total clients served statewide. Finally, the Division can collect additional funds by ensuring it bills Medicaid for all eligible clients.

Case Management Fee Did Not Reflect Actual Cost

The Division could have collected about $1.2 million in additional federal funds if targeted case management (TCM) services had been billed at actual cost for fiscal years 2004 and 2005. Until recently, the Division did not have the information needed to establish the actual cost. Since this information is now readily available, the Division needs to adjust its fees to reflect actual cost after each fiscal year ends. We also noted controls need to be developed to ensure agency costs are allocated appropriately between case management and other services before fees are set.

Fee Was Based on Estimated Hours of Service

The TCM fee charged by the regional centers in fiscal years 2004 and 2005 was $91 per hour. The regional centers based the fee on estimated costs and case management hours worked per staff. Although the Division revised its TCM fee in February 2004, it did not recalculate the fee when the actual costs and hours of service for fiscal year 2004 were known.

The Division did not revise the TCM fee based on actual cost because in past years actual units of service were not readily available. Previously, staff recorded case

management services manually, which made compiling the hours of service very time-consuming and prone to error. However, beginning in fiscal year 2004, all three regional centers recorded case management services in a new automated information system. Recording these services in the automated system enables the Division to generate management reports very easily, including the actual hours of service provided during the year.

With this information now readily available, we obtained the actual hours of case management services in fiscal year 2004 and computed the actual cost of these services. Although the regional centers charged $91 per hour, our calculations determined the actual cost of providing case management services was a little over $103 per hour. Exhibit 3 shows the additional federal funds we estimate the Division could have collected for fiscal years 2004 and 2005 based on the $12 per hour variance.

Exhibit 3

Targeted Case Management Fees
Additional Collections Based on Actual Costs
Fiscal Years 2004 and 2005

FY	Hours Billed	X	Rate Variance	=	Total Variance	X	Federal Share	=	Additional Funds
2004	83,021		$12.36		$1,026,140		55%		$564,377
2005	91,640		$12.36		$1,132,670		55%		$622,969

Source: Auditor analysis of developmental services agencies' records.

At the time of our audit, detailed cost breakdowns by service were not yet available for fiscal year 2005. As a result, the 2005 estimate assumes the actual cost of case management services in fiscal year 2005 is the same as fiscal year 2004. Agency personnel agreed with our calculation of the actual cost and estimated additional federal funds. In addition, State Medicaid representatives agreed the Division could re-bill Medicaid for the actual cost of providing case management services in fiscal years 2004 and 2005. Since there is a 2-year limit on re-billing, the Division should work with State Medicaid representatives to resolve this promptly. By re-billing Medicaid promptly, the Division can collect the additional federal funds for services provided in fiscal year 2005 and part of fiscal year 2004.

Controls Needed to Ensure Cost Data Is Accurate

The Division has not established controls to help ensure Medicaid cost reports are accurate. As a result, we found several errors in the fiscal year 2004 cost reports prepared by Sierra Regional Center (SRC) and Desert Regional Center (DRC). The centers must allocate costs between the services provided, including case management, to prepare the report. Therefore, errors will impact the fees charged.

SRC and DRC bill for Intermediate Care Facility for the Mentally Retarded (ICF/MR) services during the year at an estimated daily rate. After year-end, staff prepare the ICF/MR cost reports to determine how much was reimbursed compared to what should have been the actual daily rate. The centers then submit the reports to Medicaid for review and final settlement. Our examination of the fiscal year 2004 reports showed SRC had overstated its ICF/MR reimbursable costs by about $1.6 million and DRC overstated costs by $230,000. Both centers submitted amended reports after we notified them of the errors. Since the final Medicaid review and settlement had not occurred, there was no financial impact from these errors.

The errors can be attributed to control weaknesses with the report preparation process. For instance, the cost reports are not reviewed by anyone at the regional centers before submitting them to Medicaid. We also noted a lack of written procedures on preparing the cost reports. This weakness contributed to the errors in the DRC cost report, according to agency personnel who prepared the report for the first time in fiscal year 2004.

Recommendations

1. Work with State Medicaid representatives to re-bill Medicaid at the actual cost for case management services provided in fiscal years 2004 and 2005.
2. Develop written procedures on setting case management fees, including year-end adjustments needed to reflect the actual cost of providing the services.
3. Develop written procedures on preparing the ICF/MR cost report, including controls to detect significant errors.

Modifications Will Enhance the New Billing System's Effectiveness

The new billing system developed in-house and piloted at the Sierra Regional Center was effective. We estimate SRC billed for almost 98 percent of the total amount it should have billed to Medicaid. Nevertheless, SRC has opportunities to increase its collection of federal funds from Medicaid by about $235,000 annually by making further improvements. In addition, the Division needs to prepare better documentation of the new system and to separate key duties to help ensure the effective operation of the system. SRC has already corrected some of the problems and is working on others. However, it is critical for the Division to address these improvements timely since the agency plans to implement the billing system at the other two regional centers, which account for over 75 percent of the total clients served statewide.

System Designed to Provide Management Information and Billings

SRC personnel designed a new system for the Division's regional centers to make management information more readily available and automate the Medicaid billing processes that were very time-consuming. The system is called DS-NOW (Developmental Services - News, Operations, and Web Access). Elements of the system have been used at all three regional centers since July 2003. However, the system was first used for billing purposes at SRC in fiscal year 2005, with plans to implement the billing component at the other regional centers.

When clients receive services at SRC, staff enter billing data into the system, including Medicaid eligibility, and the amount and dates that services were provided. Billable services include case management, supported living arrangements (SLAs), jobs and day training (JDT), and ICF/MR services. In order to prepare a bill, staff query the system to identify billable services, which are then printed on standard Medicaid claim forms and mailed. As Medicaid processes claims, the status of each claim is entered into DS-NOW. Services that Medicaid denies are investigated and billed again as necessary. Exhibit 4 shows the number of Medicaid claims and amounts billed by SRC for services provided from July 2004 through April 2005.

Exhibit 4

SRC Medicaid Claims
For Services Provided From July 2004 Through April 2005

Service	No. of Claims	Amount Billed
Supported Living Arrangements	2,018	$ 6,713,744
ICF/MR	344	5,901,623
Targeted Case Management	5,262	1,470,059
Jobs and Day Training	1,825	1,400,867
Family Support Arrangements	537	737,590
Counseling	240	33,196
Totals	10,226	$16,257,079

Source: Sierra Regional Center billing records.

Improvements Will Help Ensure All Services Are Billed

Our analysis of SRC's billings for the first 10 months of fiscal year 2005 indicates Medicaid was billed for almost 98 percent of the total amount that should have been billed. However, since SRC billed Medicaid about $16 million during this period, minor billing errors can have a significant impact on revenue. As a result, we determined SRC did not bill services totaling about $430,000. If SRC had billed these services, it would have received about $235,000 in additional federal funds. This is the federal portion of the unbilled amount.

We identified two main reasons why services were not billed – data reliability problems and misunderstandings of Medicaid rules. The Division has already fixed some problems and is working on others.

Inaccurate and Incomplete Data

SRC did not bill about $345,000 of services because of incomplete or inaccurate data. A few of the problems are explained below:

- About $133,000 in JDT services were not billed primarily because of problems with the input of data on the cost of services provided. SRC personnel subsequently simplified the manner in which this data was recorded and the amount of unbilled services decreased significantly in later months.
- About $82,000 in case management and counseling services were not billed because service records were not submitted timely. After we discussed this problem with agency personnel, SRC revised its billing procedures and this problem did not recur.
- About $58,000 of SLA and case management services were not billed because of a lack of Medicaid provider numbers and client Medicaid numbers. These problems occurred because the new system did not have

procedures to identify services that had not been billed due to incomplete data at the time bills were prepared.

- About $38,000 of SLA services were not billed when queries included incorrect eligibility dates. This was caused by queries being rewritten each month, instead of automating the process so that only key parts of the query had to be changed.

Misunderstanding of Medicaid Rules

About $83,000 of services were not billed because agency personnel misinterpreted Medicaid rules. First, about $43,000 was not billed because SRC did not realize that Medicaid reimburses for counseling services provided to all Medicaid eligible clients. SRC only billed Medicaid for clients that were waiver eligible. These are clients living in their homes or communities who, without extensive services, would require institutional care at an ICF/MR. However, only about one-third of the center's Medicaid clients are waiver eligible. Our discussions with State Medicaid personnel confirmed that Medicaid pays for counseling services for all eligible clients. Second, SRC did not bill about $40,000 of SLA and JDT services because of uncertainty regarding how to bill Medicaid for clients receiving multiple services during the month. MHDS and State Medicaid personnel stated they can develop solutions to both of these problems.

Documentation of Automated System Is Needed

The Division did not have sufficient documentation for the new billing system including an overview of how the system works and the inputs, processes, and outputs. In addition, the design, programming, and system administration was done for the most part by one person. These control weaknesses increase the risk of error or loss of state funds.

Addressing these weaknesses is critical since the regional centers receive a considerable amount of federal funds to fund their services. For instance, the centers received almost $40 million in fiscal year 2005. The centers obtain the federal funds by billing Medicaid and other agencies administering federal grants for client services. Therefore, the lack of documentation and separation of duties could negatively impact agency operations.

Since fiscal year 2004, agency personnel have spent considerable time dealing with Medicaid's new claims administrator on denied claims. In some months, Medicaid

rejected almost half of the claims submitted by the regional centers. Accordingly, SRC personnel indicated this has delayed the documentation and completion of the system that will help ensure key duties are segregated. MHDS personnel have been meeting with State Medicaid representatives to address the problems with denied claims.

Recommendations

4. Work with State Medicaid representatives to obtain reimbursement for unbilled services provided in fiscal year 2005, and to resolve billing issues related to counseling and multiple services.
5. Standardize the process for generating Medicaid bills to reduce the risk of errors.
6. Develop procedures to identify and bill for services not billed due to timing differences and missing data.
7. Document an overview of how the new billing system works, including the inputs, processes, and outputs.
8. Separate the duties of operating the system from the design and programming of the system.

Controls Needed to Ensure Medicaid Is Billed for All Eligible Clients

Billing procedures did not ensure the Division billed Medicaid for all eligible clients. We estimate the Division could have collected about $90,000 in additional federal funds in fiscal year 2005 by billing Medicaid instead of other federal programs. In addition, the regional centers need additional controls to ensure all potentially eligible clients apply for Medicaid. Ensuring clients apply for Medicaid can help maximize federal reimbursements.

Medicaid Was Not Always Billed for Eligible Clients

The Desert Regional Center billed two federal programs for services provided to clients that were Medicaid eligible. These programs, Title XX and Temporary Assistance to Needy Families (TANF), reimburse the Division for eligible clients receiving some Medicaid-covered services such as case management, and jobs and day training. However, the amount of expenditures that Medicaid reimburses is not

limited, while the amounts reimbursable under Title XX and TANF are capped each year. Therefore, DRC should only bill Title XX and TANF for services that are not eligible for Medicaid reimbursement.

Although DRC had more than enough eligible expenditures to collect the entire fiscal year 2005 Title XX and TANF allotments, these programs were billed about $114,000 for Medicaid clients. Exhibit 5 shows the services that were billed to Title XX and TANF instead of Medicaid.

Exhibit 5

Services Billed to Title XX and TANF Instead of Medicaid in Fiscal Year 2005

Service	Amount Billed to Title XX	Amount Billed to TANF	Total
Jobs and Day Training (JDT)	$101,000	$ --	$101,000
Targeted Case Management (TCM)	--	12,600	12,600
Total	$101,000	$12,600	$113,600

Source: Analysis of Title XX and TANF billings.

Furthermore, JDT services totaling about $50,000 that were provided to some of these Medicaid clients after DRC received its Title XX allotment, were not billed to Medicaid. Billing Medicaid for these services would have resulted in approximately $90,000 in additional federal funds. By its billing procedures for clients eligible for more than one federal program, DRC can ensure federal revenues are maximized in future years. Agency personnel agreed that using Title XX and TANF funds only for non-Medicaid expenses will help maximize federal revenues.

Controls Can Be Strengthened to Ensure Medicaid Eligibility Is Pursued

Although a significant percentage of clients were Medicaid eligible, additional controls will help ensure Medicaid eligibility is pursued for all clients. Control weaknesses included a lack of written procedures and supervisory oversight of service coordinators' efforts in this area. Written procedures would provide guidance explaining staff responsibilities, including documentation necessary to assess whether clients should apply for Medicaid. Since over half of the cost of Medicaid eligible services is reimbursed by federal funds, pursuing eligibility reduces the amount of state funds needed to provide developmental services.

The cost of providing services to clients can be from several hundred to several thousand dollars per month. For eligible clients, Medicaid reimburses the Division for most of the services provided by the regional centers. Therefore, even though over 80 percent of the centers' clients were Medicaid eligible in fiscal year 2005, the regional centers need enhanced controls to help ensure all clients eligible for Medicaid are billed. These controls will help ensure federal reimbursements are maximized. Furthermore, clients benefit from having health insurance through Medicaid, since it covers a wide variety of health care services not provided by the regional centers.

Recommendations

9. Modify billing procedures to ensure Title XX and TANF programs are not billed for services reimbursable by Medicaid.
10. Develop written policies and procedures to provide additional guidance to service coordinators on assisting clients in pursuing Medicaid eligibility, including documentation needed.
11. Provide supervisory oversight to ensure Medicaid eligibility is pursued for all clients that are potentially eligible.

Appendices

Appendix A
Audit Methodology

To gain an understanding of the Division of Mental Health and Developmental Services (MHDS), we interviewed agency staff and reviewed statutes, regulations, and policies and procedures significant to the Division's operations. In addition, we reviewed the agency's financial information, prior audit reports, budgets, minutes of various legislative committees, and other information describing the activities of the Division.

To determine if the Division is maximizing federal reimbursements for the cost of providing developmental services, we performed various procedures. First, we evaluated procedures used at DRC and SRC to establish fees for ICF/MR services to determine if the rates were based on costs. This included verifying the ICF/MR cost reports submitted to Medicaid agreed to the state's accounting system and agency records, determining whether the cost allocation process was reasonable, and examining records related to the number of days of service. We also evaluated procedures used to establish the fee charged for case management services and determined the actual cost to provide these services in fiscal years 2004 and 2005. Then, we estimated the amount of additional federal funds that the regional centers could collect by re-billing Medicaid for case management services at the actual cost. To confirm the regional centers could re-bill Medicaid for the actual cost of providing case management services, we met with State Medicaid representatives.

Our procedures also included reviewing the newly automated billing system (DS-NOW) used at SRC during fiscal year 2005 to determine whether federal programs were billed correctly. This included testing ICF/MR services for all clients receiving services in two randomly selected months (67 clients). In addition, we randomly selected 40 clients receiving targeted case management services and tested all services they received in one of two randomly selected months. We also randomly selected 80 payments to community-based service providers (40 residential placements

and 40 jobs and day training) for testing. We selected these items from the first 10 months of fiscal year 2005, since SRC had billed for these months at the time our testing was performed. For each unbilled service, we worked with SRC personnel to determine the cause(s). Once we understood the cause(s), we performed queries of DS-NOW to identify all other instances of unbilled services and provided them to SRC personnel for confirmation.

We then evaluated procedures used at DRC, SRC, and RRC to pursue a client's eligibility in order to maximize federal reimbursements. This test included assessing agency efforts for a total of 55 cases at the regional centers.

Finally, we determined whether the regional centers are appropriately billing Medicaid when a client is eligible for more than one federal program. There were three federal programs (Medicaid, Title XX, and TANF) which the centers billed for services. Since Medicaid does not have any limit on the amount of federal funds that can be obtained, unlike the other two federal programs, all services eligible for Medicaid should be billed to Medicaid. Therefore, we reviewed services billed to Title XX and TANF to determine if the regional centers should have billed any services to Medicaid instead.

Our audit work was conducted from October 2004 to October 2005, 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 Mental Health and Developmental Services. On April 7, 2006, we met with agency officials to discuss the results of our audit and requested a written response to the preliminary report. That response is contained in Appendix D, which begins on page 23.

Contributors to this report included:

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Appendix B
Prior Audit Recommendations

As part of our audit, we requested the Division of Mental Health and Developmental Services determine the status of the recommendations made in our 2000 audit. That audit contained 15 recommendations related to maximizing non-state revenues for inpatient mental health care at Northern Nevada Adult Mental Health Services (known as the Nevada Mental Health Institute in 2000). The Division indicated that nine recommendations were fully implemented and six recommendations were partially implemented. The scope of our current audit did not include mental health services. Therefore, we did not verify the Division's implementation of the prior audit recommendations.

Appendix C

Developmental Services Expenditures
Fiscal Year 2005

Description	Rural Regional Center	Sierra Regional Center	Desert Regional Center	Total
Personnel	$1,369,771	$ 8,363,523	$13,747,545	$23,480,839
Travel	44,361	20,583	94,212	159,156
Operating	176,417	952,031	1,572,465	2,700,913
Equipment	5,211	9,152	49,562	63,925
Information Services	32,714	65,846	128,334	226,894
Residential Placement	5,657,423	11,770,086	25,215,831	42,643,340
Family Support[(1)]	202,976	308,794	1,769,110	2,280,880
Jobs and Day Training	1,998,062	3,719,531	10,899,291	16,616,884
Mojave[(2)]	--	18,479	93,902	112,381
Total	**$9,486,935**	**$25,228,025**	**$53,570,252**	**$88,285,212**

(1) Includes Family Preservation Program expenditures.

(2) Mental health services provided to clients referred from the regional centers.

Appendix D

Response From the Division of Mental Health and Developmental Services

STATE OF NEVADA
DIVISION OF MENTAL HEALTH
AND DEVELOPMENTAL SERVICES
Kinkead Building, Room 602
505 E. King Street
Carson City, Nevada 89701-3790
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KENNY C. GUINN
Governor

MICHAEL J. WILLDEN
Director

CARLOS BRANDENBURG, Ph.D.
Administrator

DEBBIE HOSSELKUS
Deputy Administrator

April 21, 2006

Mr. Paul V. Townsend, CPA
Legislative Auditor
Legislative Counsel Bureau
401 S Carson Street
Carson City, NV 89701-4747

Dear Mr. Townsend:

Please accept this letter in response to audit recommendations issued in your letter dated April 11, 2006.

I want to express my appreciation to you and your staff for completing a balanced review of our operations. Your staff was professional and courteous throughout the audit. The audit resulted in recommendations that will help us improve the efficiency of billing process and help us maximize collections of federal funding.

I also appreciate your willingness to acknowledge the hard work and effort put forward by our staff in the development of a functional billing system that accomplished billing for 98% of available Medicaid funding.

The following are our responses to the audit recommendations:

Recommendation 1: Work with State Medicaid representatives to re-bill Medicaid at the actual cost for case management services provided in fiscal years 2004 and 2005

Response: We accept this recommendation. Fiscal 2004 rates have been adjusted to reflect actual costs. We have submitted the new rates to DHCFP and have initiated the process to receive reimbursement for available months. Fiscal 2005 rates are currently being adjusted. We plan to submit the new rates, reflecting costs, in May 2006.

Recommendation 2: Develop written procedures on setting case management fees, including year-end adjustments needed to reflect the actual cost of providing the services.

Response: We accept this recommendation. Staff has developed a standard spreadsheet that assists in the calculation of rates based upon cost reports. Policies and procedures will be completed in the future.

Recommendation 3: Develop written procedures on preparing the ICF/MR cost report, including controls to detect significant errors.

Response: We accept this recommendation. The spreadsheet noted above provides a check to identify significant errors. Additionally, procedures will be developed to prevent errors from going undetected. These procedures will include review of cost reports and related Medicaid rates by the Division internal auditor.

Recommendation 4: Work with State Medicaid representatives to obtain reimbursement for unbilled services provided in fiscal year 2005, and to resolve billing issues related to counseling and multiple services.

Response: We accept this recommendation. We will work through DHCFP to obtain reimbursement for all Medicaid covered services, including jobs and day training, case management and supported living arrangements.

Recommendation 5: Standardize the process for generating Medicaid bills to reduce the risk of errors.

Response: We accept this recommendation. The process for generating Medicaid bills has been standardized through the use of billing software tools, such as PC Ace and Crystal Reports. We will continue work in refining this process.

Recommendation 6: Develop procedures to identify and bill for services not billed due to timing differences and missing data.

Response: We accept this recommendation. Procedures have been developed to ensure all required information is obtained and entered into the billing system. We will work to further refine the process to minimize services not billed.

Recommendation 7: Document an overview of how the new billing system works, including the inputs, processes, and outputs.

Response: We accept this recommendation. Development of procedures and documentation is essential to provide consistency and long term continuity of operations. We are documenting the process and developing a desk manual.

Recommendation 8: Separate the duties of operating the system from the design and programming of the system.

Response: We accept this recommendation. Production of billing claims has been separated from the IT staff and is now completed by accounting staff. We will continue to evaluate whether additional segregation of duties in needed.

Recommendation 9: Modify billing procedures to ensure Title XX and TANF programs are not billed for services reimbursable by Medicaid.

Response: We accept this recommendation. We now limit the use of TANF and Title XX funding to programs and services that are not eligible for Medicaid reimbursement. System controls are being developed to ensure that only non-Medicaid services are funded using TANF or Title XX funds.

Recommendation 10: Develop written policies and procedures to provide additional guidance to service coordinators on assisting clients in pursuing Medicaid eligibility, including documentation needed.

Response: We accept this recommendation. Written procedures will be developed to ensure service coordinators and intake staff gather appropriate information to determine if clients should apply for Medicaid eligibility.

Recommendation 11: Provide supervisory oversight to ensure Medicaid eligibility is pursued for all clients that are potentially eligible.

Response: We accept this recommendation. Management is developing reports of all clients who are not eligible for Medicaid. These reports will be provided to service coordinators to allow them to periodically review the financial status of their clients. Supervisors will review these reports with service coordinators to determine if additional steps need to be taken to pursue Medicaid eligibility. The Division Internal Auditor will review and test this process as part of periodic agency reviews.

Thank you for the opportunity to respond to the recommendations. If you have any questions, please contact Jeff Mohlenkamp at 684-5977.

Sincerely,

Carlos Brandenburg

Cc: Mike Willden, Director, DHHS
Mike Torvinen, Deputy Director, Fiscal, DHHS
Debbie Hosselkus, Deputy Administrator, MHDS
Jane Gruner, Acting Cirector SRC
Nancy Knox, Director, DRC
Marcia Bennett, Director, RRC

Division of Mental Health and Developmental Services
Response to Audit Recommendations

Recommendation Number		Accepted	Rejected
1	Work with State Medicaid representatives to re-bill Medicaid at the actual cost for case management services provided in fiscal years 2004 and 2005……...	X	
2	Develop written procedures on setting case management fees, including year-end adjustments needed to reflect the actual cost of providing the services	X	
3	Develop written procedures on preparing the ICF/MR cost report, including controls to detect significant errors	X	
4	Work with State Medicaid representatives to obtain reimbursement for unbilled services provided in fiscal year 2005, and to resolve billing issues related to counseling and multiple services	X	
5	Standardize the process for generating Medicaid bills to reduce the risk of errors	X	
6	Develop procedures to identify and bill for services not billed due to timing differences and missing data	X	
7	Document an overview of how the new billing system works, including the inputs, processes, and outputs....	X	
8	Separate the duties of operating the system from the design and programming of the system	X	
9	Modify billing procedures to ensure Title XX and TANF programs are not billed for services reimbursable by Medicaid	X	
10	Develop written policies and procedures to provide additional guidance to service coordinators on assisting clients in pursuing Medicaid eligibility, including documentation needed	X	
11	Provide supervisory oversight to ensure Medicaid eligibility is pursued for all clients that are potentially eligible	X	
	TOTALS	11	0